COORDINATED CARE NETWORKS – SHARED MODEL (CCN-S)

LOUISIANA MEDICAID COORDINATED CARE PROGRAM
BUREAU OF HEALTH SERVICES FINANCING
DEPARTMENT OF HEALTH AND HOSPITALS

RFP # 305PUR-DHHRFP-CCN-S-MVA
Proposal Due Date/Time: June 24, 2011/ 4:00 PM CDT

Release Date: APRIL 11, 2011

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COMPANION GUIDES

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2. CCN-S System Companion Guide
3. Quality Companion Guide (TBE)
4. State Fair Hearing Companion Guide

1. GENERAL INFORMATION

1.1. Background

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

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

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

BHSF consists of the following Sections: Medicaid Coordinated Care, Program Operations, Medicaid Management Information System (MMIS), Financial Operations, Waivers and Supports, Program Integrity, Behavioral Health, Policy & Planning, Pharmacy, Eligibility Field Operations, Eligibility Program and Policy, Eligibility Supports, Eligibility Special Services, and Eligibility Systems, and Health Standards. The Medicaid Coordinated Care Sections has primary responsibility for implementation and ongoing operations of all Medicaid coordinated care delivery models, including CommunityCARE 2.0 (CC 2.0), comprehensive prepaid coordinated care and shared saving models through Coordinated Care Networks (CCNs).

1.2. Expected Outcomes of the Medicaid CCN Program

The expected outcomes of the Medicaid CCN Program include providing:

- Improved coordination of care;

- A patient-centered medical home for Medicaid recipients;
- Better health outcomes;
- Increased quality of care as measured by metrics such as HEDIS;
- Greater emphasis on disease prevention and management of chronic conditions;
- Earlier diagnosis and treatment of acute and chronic illness;
- Improved access to essential specialty services;
- Outreach and education to promote healthy behaviors;
- Increased personal responsibility and self management;
- A reduction in the rate of avoidable hospital stays and readmissions;
- A decrease in fraud, abuse, and wasteful spending;
- Greater accountability for the dollars spent;
- A more financially sustainable system; and
- Net savings to the State, when compared to the existing fee-for-service Medicaid delivery system.

1.3. Purpose of RFP

The purpose of this Request for Proposal (RFP) is to solicit proposals from qualified entities to provide healthcare services to Medicaid enrollees participating in the Medicaid Coordinated Care Network (CCN) project, utilizing the most cost effective manner and in accordance with the terms and conditions set forth herein.

Through this RFP, DHH will solicit proposals from entities to serve as a Shared Savings Coordinated Care Network (CCN-S) in one or more of the three Geographic Service Areas (GSAs) within the State. The GSAs are comprised of DHH Administrative Regions as follows:

a. GSA A: DHH Administrative Regions 1 and 9

- Region 1:
  - Jefferson
  - Plaquemines
  - Orleans
  - St. Bernard

- Region 9:
  - Livingston
  - St. Helena
  - St. Tammany

- Tangipahoa
- Washington

b. GSA B: DHH Administrative Regions 2, 3, and 4

- Region 2:
  - Ascension
  - East Baton Rouge
  - East Feliciana
  - Iberville
  - Point Coupee
  - West Baton Rouge
  - West Feliciana

- Region 3:
  - Assumption
  - Lafourche
  - St. Charles
  - St. John
  - St. James
  - St. Mary
  - Terrebonne

- Region 4:
  - Acadia
  - Evangeline
  - Iberia
  - Lafayette
  - St. Landry
  - St. Martin
  - Vermillion

c. GSA C: Regions 5, 6, 7, and 8

- Region 5:
  - Allen
  - Beauregard
  - Cameron
  - Calcasieu
  - Jefferson Davis

- Region 6:
  - Avoyelles

  - Catahoula
  - Concordia
  - Grant
  - LaSalle
  - Rapides
  - Vernon
  - Winn

- Region 7:
  - Bienville
  - Bossier
  - Caddo
  - Claiborne
  - DeSoto
  - Natchitoches
  - Red River
  - Sabine
  - Webster

- Region 8:
  - Caldwell
  - East Carroll
  - Franklin
  - Jackson
  - Lincoln
  - Madison
  - Morehouse
  - Ouachita
  - Richland
  - Tensas
  - Union
  - West Carroll

Refer to Appendix D for map of parishes within each GSA.

This RFP solicits proposals; details proposal requirements; defines DHH's minimum service requirements; and outlines the State's process for evaluating proposals and selecting the contractors.

Through this RFP, the DHH seeks to contract for the needed services and to give ALL qualified businesses, including those that are owned by minorities, women, persons with disabilities, and small business

enterprises, opportunity to do business with the State as contractors and subcontractors.

This RFP process is being used so that the Department may selectively contract with a limited number of qualified entities. The RFP will provide DHH with the opportunity to ensure that the CCN-S is capable of implementing an acceptable care management system that provides for a medical home.

A Contract is necessary to provide the Department with the ability to ensure accountability while improving access, coordinating care and promoting healthier outcomes.

Authority for the DHH to implement the CCN Program is contained in La R.S. 36:254 which provides the Secretary of DHH with the authority to implement coordinated care requirements of HB 1 of the 2010 Regular Session of the Louisiana Legislature.

The Department will attain this goal by enrolling eligible Medicaid enrollees in CCNs that contract with the Department to provide the specified scope of services to each enrolled member in return for a payment made on a per member, per month (PMPM) basis.

1.4. Federal Authority

Federal authority for DHH to implement the CCN program is contained in Section 1932(a)(1)(A) of the Social Security Act as amended and 42 CFR Part 438 as those requirements as they apply to primary care management (PCCM) programs. DHH intends to submit a State Plan Amendment to implement the CCN program

1.5. Invitation to Propose

DHH is inviting qualified proposers to submit proposals to provide specified health care services in three (3) defined GSAs for Medicaid recipients enrolled in the CCN Program in return for a monthly enhanced primary care case management fee made in accordance with the specifications and conditions set forth herein. Proposers may submit proposals for one, two, or all three GSAs. The minimum service area is one (1) GSA.

1.6. RFP Coordinator

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

Ruth Kennedy
Medicaid CCN Project Director
Louisiana Department of Health and Hospitals
628 North 4th Street, Baton Rouge, LA 70802
Telephone Number: (225) 342-3032
Facsimile Number: (225) 376-4808
E-mail: Ruth.Kennedy@la.gov

This RFP is available in pdf at the following weblinks:

http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47[dwv1] and
http://wwwprd.doa.louisiana.gov/OSP/LaPAC/bidlist.asp?department=4, and
http://www.makingmedicaidbetter.com

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

1.7. Proposer Comments

Each Proposer must carefully review this RFP and department issued Companion Guides, including but not limited to the *pro forma* Contract, for comments, questions, defects, objections, or any other matter requiring clarification or correction (collectively called "comments").

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

(1) Has waived any claim of error or ambiguity in the RFP or resulting contract;

(2) Cannot contest DHH's interpretation of such provision(s); and

(3) Will not be entitled to additional compensation, relief or time by reason of the ambiguity, error, or its later correction

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

The Proposer must provide an electronic copy of the comments in an MS Excel table in the format specified below:

Proposer Name	Section Number	Section Heading	Page Number in Referenced Document	Question

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

http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47[dwv1] and http://wwwprd.doa.louisiana.gov/OSP/LaPAC/bidlist.asp?department=4, and http://www.makingmedicaidbetter.com

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

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

1.8. Notice of Intent to Propose

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

- Company Name
- DHH Geographic Service Areas (GSAs) proposing to serve
- Name and title of a contact person
- Mailing address, email address, telephone number, and facsimile number of the contact person

NOTICE: A Notice of Intent to Propose creates no obligation and is not a prerequisite for making a proposal. However entities submitting a Notice of Intent to Propose will receive e-mail notification of the Internet posting of RFP addendums and other communications regarding the RFP.

1.9. Pre-Proposal Conference

A pre-proposal conference will be held on the date and time listed on the Schedule of Events. Prospective proposers are encouraged to participate in the conference to obtain clarification of the requirements of the RFP and to receive answers to relevant questions.

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

http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47[dwv1] and
http://wwwprd.doa.louisiana.gov/OSP/LaPAC/bidlist.asp?department=4,and
http://www.makingmedicaidbetter.com

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

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

1.10. Schedule of Events

DHH reserves the right to deviate from this Schedule of Events:

SCHEDULE OF EVENTS	TENTATIVE SCHEDULE
Public Notice of RFP	April 11, 2011
Pre-Proposal Conference	April 18, 2011 1:00 pm – 4:00 pm CDT Room 118 Bienville Building 628 North 4th Street Baton Rouge, LA 70802
Rate Conference	April 19, 2011 9:00 am – 12:00 pm CDT Room 118, Bienville Building 628 North 4th St Baton Rouge, LA 70802
Systems and Technical Conference	April 19, 2011 1:00 pm - 4:00 pm CDT Room 118, Bienville Building 628 North 4th St Baton Rouge, LA 70802
Deadline for Receipt of Written Questions	April 29, 2011 11:00 pm CDT
Deadline for Receipt of Letter of Intent to Propose	May 6, 2011 11:00 pm CDT
Deadline for DHH Responses to Written Questions	May 23, 2011

Schedule of Events	Tentative Schedule
Deadline for Receipt of Follow-Up Written Questions	May 27, 2011 11:00 pm CDT
Deadline for DHH Responses to Follow-Up Written Questions	June 10, 2011
Deadline for Receipt of Written Proposals	June 24, 2011 4:00 pm CDT
Proposal Evaluation Begins	June 25, 2011
Contract Award Announced	July 25, 2011
Contract Negotiations Begin	July 25,, 2011 – August 8, 2011
Deadline for Contracts Signed by CCN and DHH*	August 8, 2011
Contracts submitted to DOA/OCR for Approval	August 8, 2011
DOA/OCR Approval	September 1, 2011
Geographic Service Area A	
Readiness Reviews Begin	September 1, 2011
GSA Network Adequacy Documentation Deadline	October 7, 2011

SCHEDULE OF EVENTS	TENTATIVE SCHEDULE
CCN Network & Contract Submitted to CMS for Approval	October 17, 2011
Deadline for Completion of On-Site Readiness Review	October 15, 2011
Deadline for CCN Network Provider Directory and One Page Brochure to Enrollment Broker	November 8, 2011
CMS Approval for CCN Network and Contract	November 15, 2011
Choice Letters Mailed to Enrollees & Enrollment Begins	November 15, 2011
Deadline for Member Enrollment	December 23, 20011
"Go Live" Date	January 1, 2012
Geographic Service Area B	
Readiness Reviews Begin	September 19, 2011
GSA Network Adequacy Documentation Deadline	November 7, 2011
CCN Network & Contract Submitted to CMS for Approval	December 16, 2011
Deadline for Completion of On-Site Readiness Review	January 2, 2012
Deadline for CCN Network Provider Directory and One Page Brochure to Enrollment Broker	January 6, 2012

Schedule of Events	Tentative Schedule
CMS Approval for CCN Network and Contract	January 15, 2012
Choice Letters Mailed to Enrollees & Enrollment Begins	January 16, 2012
Deadline for Member Enrollment	February 23, 2012
"Go Live" Date	March 1, 2011
Geographic Service Area C	
Readiness Reviews Begin	September 1 – December 1, 2012
GSA Network Adequacy Documentation Deadline	January 9, 2012
CCN Network & Contract Submitted to CMS for Approval	February 15, 2012
Deadline for Completion of On-Site Readiness Review	March 5, 2012
Deadline for CCN Network Provider Directory and One Page Brochure to Enrollment Broker	March 9, 2012
CMS Approval for CCN Network and Contract	March 14, 2012
Choice Letters Mailed to Enrollees & Enrollment Begins	March 15, 2012
Deadline for Member Enrollment	April 25, 2012

SCHEDULE OF EVENTS	TENTATIVE SCHEDULE
"Go Live" Date	May 1, 2012

***The event specified is the date by which the contracts must signed by the CCN and DHH. Contracts are not valid until approved by the Division of Administration and CMS.**

1.11. RFP Addenda

In the event it becomes necessary to revise any portion of the RFP for any reason, the Department shall post addenda, supplements, and/or amendments to all potential proposers known to have received the RFP. Additionally, all such supplements shall be posted at the following web address:

http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47[dwv1] and http://wwwprd.doa.louisiana.gov/OSP/LaPAC/bidlist.asp?department=4, and http://www.makingmedicaidbetter.com

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2.0 POPULATIONS COVERED

2.1 Eligibility and Included Populations

DHH determines eligibility for Medicaid and CHIP for all coverage groups except for Supplemental Security Income (SSI), Family Independence Temporary Assistance Program (FITAP), and Foster Care. The Social Security Administration (SSA) determines eligibility for SSI and the Department of Social Services (DSS) determines eligibility for FITAP and Foster Care. Once an applicant is determined eligible for Medicaid or CHIP by DHH, DSS, or SSA, the pertinent eligibility information is entered in the Medicaid Eligibility Determination System (MEDS).

Eligibility criteria for the Louisiana Medicaid CCN Program are the same as the eligibility criteria for the Louisiana Medicaid and CHIP Programs.

2.2 Duration of Medicaid Eligibility

2.2.1 Children under age 19 enrolled in Medicaid or CHIP receive 12 months continuous eligibility, regardless of changes in income or household size.

2.2.2 Individuals who attain eligibility due to a pregnancy are guaranteed eligibility for comprehensive services through two months post-partum or post-loss of pregnancy.

2.2.3 Renewals of Medicaid and CHIP eligibility are conducted annually and do not require a face-to-face interview or signed application as DHH may conduct *ex parte* renewals, Express Lane Eligibility (ELE) renewals for children under age 19 receiving Supplemental Nutrition Assistance Program (SNAP) benefits, and telephone renewals.

2.3 Enrollment Population

2.3.1 Mandatory Populations

Medicaid groups mandated to participate in CCN include the following:

2.3.1.1 Children under 19 years of age including those who are eligible under Section 1931 poverty-level related

groups and optional groups of older children in the following categories:

- **Section 1931 - (Low Income Families with Children)** - Individuals and families who meet the eligibility requirements of the AFDC State Plan in effect on July 16, 1996;

- **TANF** - Individuals and families receiving cash assistance through FITAP, administered by the DCFS;

- **CHAMP-Child Program** – Poverty level children up to age 19 with income at our below 100% FPL for children 6 to 19 and at or below 133% FPL for children age 0 to 6, who meet financial and non-financial eligibility criteria. Deprivation or uninsured status is not an eligibility requirement;

- **Deemed Eligible Child Program** - Infants born to Medicaid eligible pregnant women, regardless of whether or not the infant remains with the birth mother, throughout the infant's first year of life;

- **Youth Aging Out of Foster Care** - Children under age 21 who were in foster care (and already covered by Medicaid) on their 18th birthday, but have aged out of foster care;

- **Regular Medically Needy Program** - Individuals and families who have more income than is allowed for regular on-going Medicaid but but can qualify on the basis that their income is spent or obligated for medical expenses;

2.3.1.2 **LaCHIP Program** - Children with income at or below 200% FPL enrolled in the Title XXI Medicaid expansion CHIP program for low-income children under age 19 who do not otherwise qualify for Medicaid, including LaCHIP Phases I, II, and III.

2.3.1.3 **Parents** eligible under Section 1931 and optional caretaker relative groups including:

- Section 1931 LIFC Program
- TANF (FITAP) Program
- Regular Medically Needy Program

2.3.1.4 **Pregnant Women** - Individuals whose basis of eligibility is pregnancy, who are eligible only for pregnancy related services {42 CFR§ 440.210(2)} including:

- LaMOMS (CHAMP-Pregnant Women) - Pregnant women otherwise ineligible for Medicaid with family income at or below 200% FPL who receive coverage for prenatal care, delivery, and care sixty (60) days after delivery and
- LaCHIP Phase IV Program – Separate State CHIP Program for CHIP Unborn Option which covers uninsured pregnant women ineligible for Medicaid, with family income at or below 200% FPL from conception to birth.

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

2.3.1.6 **Aged, Blind & Disabled (ABD) Adults –** Individuals, 19 or older, who do not meet any of the conditions for exclusion from participation in a CCN, including:

- **Supplemental Security Income (SSI) Program** - Individuals 19 and older who receive cash payments under Title XVI (Supplemental Security Income) administered by the Social Security Administration and

- **Extended Medicaid Programs** - Certain individuals who lose SSI eligibility because of a Social Security cost of living adjustment (COLA) or in some cases entitlement to or an increase in Retirement, Survivors, Disability Insurance (RSDI) benefits, i.e., Social Security benefits. SSI income standards are used in combination with budgeting rules which allow the exclusion of cost of living adjustments and/or certain benefits. Extended Medicaid consists of the following programs:

  - **Disabled Adult Children** - Individuals over 19 who become blind or disabled before age 22 and lost SSI eligibility on or before July 1, 1987, as a result of entitlement to or increase in RSDI Child Insurance Benefits;

  - **Disabled Widows/Widowers** - Disabled widows/widowers who would be eligible for SSI had there been no elimination of the reduction factor and no subsequent COLAs;

  - **Early Widows/Widowers** - Individuals who lose SSI eligibility because of receipt of RSDI early widow/widowers benefits;

  - **Pickle** - Aged, blind, and disabled persons who become ineligible for SSI or MSS as the result of cost of living increase in RSDI or receipt and/or increase of other income including:

    - Group One - Individuals who concurrently received and were eligible to receive both SSI and RSDI in at least one month since April 1, 1977, and lost SSI as the direct result of an RSDI COLA and

    - Group Two - Individuals who were concurrently eligible for and received

both SSI and RSDI in at least one month since April 1, 1977, and lost SSI due to receipt and/or increase of income other than an RSDI COLA, and would again be eligible for SSI except for COLAs received since the loss of SSI;

- **Disabled Widows/Widowers and Disabled Surviving Divorced Spouses Unable To Perform Any Substantial Gainful Activity**- Widow/widowers who are not entitled to Part A Medicare who become ineligible for SSI due to receipt of SSA Disabled Widow/widowers Benefits so long as they were receiving SSI for the month prior to the month they began receiving RSDI, and they would continue to be eligible for SSI if the amount of the RSDI benefit were not counted as income;

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

- **Medicaid Purchase Plan Program** - Working individuals between ages 16 and 65 who have a disability that meets Social Security standards; and

- **Disability Medicaid Program** - Disabled and aged (65 or older) individuals who meet all eligibility requirements of the SSI program as determined by DHH, without having an SSI determination made by SSA.

2.3.2 <u>**Voluntary Populations**</u>

2.3.2.1 Children under 19 years of age who are:

- Eligible for SSI under Title XVI;

- Eligible under Section 1902(e)(3) of the Act;
- In foster care or other out-of-home placement;
- Receiving foster care or adoption assistance;
- Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the DHH in terms of either program participation or special health care needs; or
- Enrolled in the Family Opportunity Act Medicaid Buy-In Program.

2.3.2.2 **Native Americans** who are members of federally recognized tribes, except when the MCO is:

- The Indian Health Service; or

- An Indian health program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service.

2.3.3 **Excluded Populations**

Medicaid eligibles that cannot voluntarily enroll with a CCN include:

2.3.3.1 Individuals receiving hospice services;

2.3.3.2 Individuals residing in Nursing Facilities (NF) or Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD);

2.3.3.3 Individuals who receive both Medicaid and Medicare (Medicare dual eligibles):

2.3.3.4 Individuals who have been diagnosed with tuberculosis, or suspected of having tuberculosis, and are receiving tuberculosis-related services through the Tuberculosis Infected Individual Program;

2.3.3.5 Individuals receiving services through any 1915(c) Home and Community-Based Waiver including, but not limited to:

- Adult Day Health Care (ADHC) - Direct care in a licensed adult day health care facility for those individuals who would otherwise require nursing facility services;
- New Opportunities Waiver (NOW) - Individuals who would otherwise require ICF/DD services;
- Elderly and Disabled Adult (EDA) - Services to persons aged 65 and older or disabled adults who would otherwise require nursing facility services;
- Children's Choice (CC) - Supplemental support services to disabled children under age 18 on the NOW waiver registry;
- Residential Options Waiver (ROW) - Individuals living in the community who would otherwise require ICF/DD services;
- Supports Waiver – Individuals 18 years and older with mental retardation or a developmental disability which manifested prior to age 22; and
- Other HCBS waivers as may be approved by CMS.

2.3.3.6 Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the Office for Citizens with Developmental Disabilities' (OCDD's) Request for Services Registry, also known as *Chisholm* Class Members;

2.3.3.7 Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE), a community-based alternative to placement in a nursing facility that

includes a complete "managed care" type benefit combining medical, social and long-term care services;

2.3.3.8 Individuals with a limited eligibility period including:

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

- Emergency Services Only - Emergency services for aliens who do not meet Medicaid citizenship/ 5-year residency requirements;

- Continued Medicaid Program - Short-term coverage for families who lose LIFC or TANF eligibility because of child support collections, an increase in earnings, or an increase in the hours of employment; and

2.3.3.9 Individuals enrolled in the LaCHIP Affordable Plan Program (LaCHIP Phase V) the separate state CHIP program that provides benchmark coverage with a premium to uninsured children under age 19 whose household income is from 201% FPL to 250% FPL.

2.3.3.10 Individuals enrolled in the Section 1115 Family Planning Waiver known as Take Charge that provides family planning services only to uninsured women ages 19 – 44 who are not otherwise eligible for Medicaid program.

2.3.3.11 Individuals enrolled in the Louisiana Health Insurance Premium Payment (LaHIPP) Program (Section 1906).

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3.0 GENERAL REQUIREMENTS

3.1. Scope of Work

Beginning in November 2011, DHH will phase-in implementation of member enrollment services into Medicaid's Coordinated Care Network Program. Services will begin January 1, 2012 for GSA A; March 1, 2012 for GSA B; and May 1st for GSA C. The Coordinated Care Network-Shared (CCN) Savings service delivery model is one of two new service delivery models being simultaneously implemented and is an enhancement to DHH's existing Medicaid primary care case management program known as CommunityCARE 2.0.

Enrollment into the Coordinated Care Program will be phased in based on DHH's GSAs. (See for Schedule of Events).

A Shared Savings CCN (CCN) differs from the current CommunityCARE 2.0 program in that the CCN is a primary care case manager that provides enhanced primary care case management in addition to being the entity contracting with primary care providers (PCP) for PCP care management. The CCN will expand the current roles and responsibilities of the primary care providers through the establishment of patient-centered medical homes and create a formal and distinct network of primary care providers to coordinate the full continuum of care while achieving budget and performance goals and benchmarks.

The CCN shall be responsible for network provider monitoring to ensure requirements such as, but not limited to, access to care; primary care provider's compliance with CCN policies; and progress of practices in implementation of patient-centered medical homes. The CCN shall provide participating primary care practices with support (e.g. education, training, tools, and provision of data relevant to patient clinical care management, systems development) necessary to transition primary care practices to patient-centered medical homes recognition as specified in this RFP and facilitate data interchange between practices and the CCN, and the CCN and DHH (e.g. performance measures).

The CCN will be responsible for components and services that include but are not limited to:

- PCP Patient-Centered Medical Home Recognition or Primary Care Home Accreditation
- Member and Provider Services

- PCP Care Management
- Chronic Care Management
- Utilization Management
- Quality Management and Compliance
- Prior Authorization and Pre-Processing of Claims
- Primary Care Provider Network Development and Referrals
- Primary Care Provider Monitoring
- Fraud and Abuse Monitoring
- Account Management and Overhead

3.2. Participation Requirements

A CCN must meet the following requirements in order to participate As a CCN in DHH's Coordinated Care Network – Shared Savings Program:

3.2.1. Meet the PCCM definition as defined in 42 CFR § 438.2;

3.2.2. Be certified by the Louisiana Secretary of State to do business in the State of Louisiana to La. R.S. 12:24;

3.2.3. Have the capability to pre-process claims (with the exception of carved-out services) and transfer data to DHH's fiscal intermediary (FI) or have a contract with an entity to perform these functions;

3.2.4. Provide financial documentation of a minimum net worth as specified in Minimum Net Worth of this RFP;

3.2.5. Post a surety bond for an amount specified by the department for the at-risk portion of the enhanced care management fee;

3.2.6. Post a Performance Bond in the amount of one million dollars ($1,000,000) or submit an irrevocable letter of credit for one million dollars ($1,000,000);

3.2.7. Not have an actual or perceived conflict of interest that, in the discretion of the department, would interfere or give the appearance of possibly interfering with its duties and obligations under this RFP, the Contract and any and all appropriate guides. Conflict of interest shall include, but is not limited to, being the fiscal intermediary contractor for the department;

3.2.8. Have network capacity to enroll a minimum of 75,000 Medicaid and LaCHIP eligibles within each GSA for which they are awarded a Contract; and

3.2.9. As determined by the Department, has successfully been awarded a Contract with the Department and has passed the readiness review.

3.3. Insurance Requirements

Insurance shall be placed with insurers with an A.M. Best's rating of no less than A-: VI. This rating requirement may be waived for Worker's Compensation coverage only. At any time, upon the request of DHH or its designee, the CCN shall provide proof of insurance required in the Contract and the CCN shall be the named insured on the insurance policy or policies.

3.3.1. Contractor's Insurance

The CCN shall not commence work under this Contract until it has obtained all insurance required herein. Certificates of Insurance, fully executed by officers of the Insurance Company shall be filed with DHH for approval. The CCN shall not allow any subcontractor to commence work on subcontract until all similar insurance required for the subcontractor has been obtained and approved. If so requested, the CCN shall also submit copies of insurance policies for inspection and approval of DHH before work is commenced. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days notice in advance to DHH and consented to by DHH in writing and the policies shall so provide.

3.3.2. Commercial General Liability Insurance

The CCN shall maintain during the life of the Contract such Commercial Liability Insurance which shall protect the CCN, and DHH, during the term covered by the Contract from claims for damages for personal injury, including accidental death, as well as for claims for property damages, which may arise from services related to the Contract, whether such services are provided by the CCN or by its subcontractors, or by anyone directly or indirectly employed by either of them, or in such a manner as to potentially impose liability to DHH. In the absence of specific regulations, at a minimum, the amount and type of coverage shall include bodily injury, property damage, errors and omissions, directors' and

officers' coverage, and Contractual liability, with combined single limits of one million dollars ($1,000,000).

3.3.3. Insurance Covering Special Hazards

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

3.3.4. Errors and Omissions Insurance

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

3.3.5. Licensed and Non-Licensed Motor Vehicles

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

3.3.6. Subcontractor's Insurance

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

3.3.7. Workers' Compensation Insurance

Before the Contract is implemented, the CCN shall obtain and maintain during the life of the Contract, Workers' Compensation Insurance for all of the CCN's employees that provide services under the Contract.

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

- The CCN shall furnish proof of adequate coverage of insurance by a certificate of insurance submitted to DHH prior to implementation of the Contract and annually thereafter or upon change in coverage and/or carrier.

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

3.4. Bond Requirements

3.4.1. Performance Bond or Substitute

The CCN shall be required to establish and maintain a performance bond of one (1) million dollars ($1,000,000) and submit a copy to DHH, for as long as the CCN has Contract-related liabilities of $50,000 or more outstanding, or 15 months following the termination date of this Contract, whichever is later, to guarantee: (1) payment of the Contractor's obligations to DHH and (2) performance by the CCN of its obligations under the Contract.

The bond must be obtained from an agent appearing on the United States Department of Treasury's list of approved sureties. The performance bond must be made payable to the State of Louisiana. The Contract and dates of performance must be specified in the performance bond. In the event that DHH exercises an option to renew the Contract for an additional period, the CCN shall be required to maintain the validity and enforcement of the bond for the specified period, pursuant to the provisions of this paragraph, in an amount stipulated at the time of Contract renewal.

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

- Paying any damages, because of a breach of the CCN's obligations under this Contract;

- Reimbursing DHH for any payments made by DHH on behalf of the CCN; and

- Reimbursing DHH for administrative expenses incurred by reason of a breach of the CCN's obligations under this Contract, including, but not limited to, expenses incurred after termination of this Contract for reasons other than the convenience of the state by DHH.

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

As an alternative to the Performance Bond, DHH, at the request of the CCN and acceptance by DHH, may secure a retainage of 10% from all billings under the Contract as surety for performance. On successful completion of Contract deliverables, the retainage amount may be released on an annual basis.

The original performance bond must be submitted to DHH. The original performance bond will have the raised engraved seal on the bond and on the Power of Attorney page. The CCN must retain a photocopy of the performance bond.

3.4.2. Fidelity Bonds

The CCN shall secure and maintain during the life of the Contract a blanket fidelity bond on all personnel in its employment. The bond shall include but not be limited to coverage for losses sustained through any fraudulent or dishonest act or acts committed by any employees of the CCN and its subcontractors.

3.4.3. Surety Bond

Within sixty (60) days from the implementation date of the CCN, the CCN shall secure, pay for, and keep in force for the duration of the Contract, a surety bond equal to the at-risk portion of the enhanced care management fee.

The Contract and dates of performance must be specified in the surety bond. The surety bond must be maintained during the life of the Contract, including all renewal/extension periods, and maintained through any shared savings calculations following

termination of the Contract and final financial settlement. DHH may release the CCN from this requirement after the termination of the Contract if DHH determines the shared savings calculation does not result in any amount due DHH, performances measure thresholds have been met, and there are no outstanding sanctions.

3.5. Federal Approval of Contract

DHH will submit the CCN Contract to the CMS Regional Office for approval. If CMS does not approve it the Contract will be considered null and void.

3.6. Administrative Simplification and Quality Improvement Committees

A CCN shall participate on DHH's established committees for administrative simplification and quality improvement, which will include physicians, hospitals, and other healthcare providers as appropriate, and at least one member of the Senate and House Health and Welfare Committees or their designees.

3.7. Minimum Net Worth

It is the responsibility of the CCN to maintain minimum net worth amounts as described in this section. At the time the CCN enters into a Contract with DHH, it must provide documentation of a minimum net worth of one million dollars ($1,000,000). A minimum of 75% of the net worth shall be maintained in cash or cash equivalents. The remaining amount required to meet the net worth requirements may consist of other assets as determined and valued by Generally Accepted Accounting Principles (GAAP).

3.7.1. The CCN shall re-evaluate their net worth six months following the initial implementation of service delivery. The CCN shall submit to DHH for approval, its re-evaluated net worth and all documentation utilized for this determination within 30 days after the initial six-month service delivery and annually thereafter or as determined necessary by DHH. The CCN shall maintain a minimum net worth amount equal to the greater of;

- $1,000,000;
- Two (2) months of enhanced primary care case management fee payments based on the last two months of payments

from DHH during the CCN's most recent audited fiscal period; or

- 8% of annual enhanced primary care case management revenue as reported on the most recent audited financial statements.

3.7.2. Should DHH determine the CCN is below the minimum net worth requirement the CCN shall have thirty (30) days upon receipt of notification by DHH to meet the requirement set forth above. If the requirements are not met, the CCN shall be subject to sanctions as specified in of the Contract.

3.8. Financial Reporting

The CCN shall submit to DHH unaudited quarterly financial statements and an annual audited financial statement. Quarterly financial statements shall be submitted no later than sixty (60) days after the close of each calendar quarter. Audited annual statements shall be submitted no later than six (6) months after the close of the CCN's fiscal year. All financial reporting shall be based on Generally Accepted Accounting Principles (GAAP). The financial statements shall be specific to the operations of the CCN rather than to a parent or umbrella organization.

The CCN shall disclose amounts included in the financial statements pertaining to any person or entity with ownership or controlling interest of 5% or more in the CCN and any of its contractors, including all entities owned or controlled by a parent or subsidiary organization. Additional information shall be available to DHH regarding related party transactions at the request of DHH, including the cost of such services as incurred by the related party. This disclosure shall include, but not be limited to, amounts paid to related third party administrators, insurers, providers, vendors, contractors and individuals.

With submission of the proposal, the CCN shall:

- Attach copies of its financial statements for the past three (3) years. If the CCN is a subsidiary of a parent organization, the CCN shall submit its financial statements or those of its parent, whichever are available. If the CCN is a new entity, without a previous or parent entity, this requirement may be waived upon documentation of the performance bond and minimum net worth requirements. The financial statements

must undergo an independent certified audit. The CCN is responsible for ensuring that this audit is performed. All audits shall include:

- The opinion of a certified public accountant;
- A statement of revenue and expenses;
- A balance sheet;
- A statement of changes in financial position; and
- A copy of all management letters;

- Provide the following pro forma financial statements for the CCN Louisiana operation. The pro forma financial statements must be prepared on an accrual basis by month for the first three years beginning with the first month of the proposed execution date of the Contract:

  - A statement of monthly revenue and expenses;
  - A monthly cash flow analysis; and
  - A balance sheet for each month;

- Provide copies of its bank statements for all its accounts;

- Provide a monthly enrollment and revenue projection corresponding to the pro forma financial statements referenced above; and

- The CCN shall provide a statement, signed by its president or chief executive officer, attesting that no assets of the CCN have been pledged to secure personal loans.

3.9. Certificate of Authority

The CCN shall submit a copy of the Certificate of Authority to do business in Louisiana, pursuant La. R.S. 24, from the Louisiana Secretary of State to DHH within thirty (30) days of the date the Contract with DHH is signed by the CCN.

3.10. Material Change to Operations

3.10.1. Material Change Definition

A material change to operations is defined as any change in overall business operations (i.e., policy, process, protocol such as prior authorization or retrospective review) which affects, or can reasonably be foreseen to affect, the CCN's ability to meet the

performance standards as described in this Contract. It also includes any change that would impact more than 5% of total membership and/or the provider network in a specific GSA.

3.10.2. The CCN must submit the request for approval of a material change to operations, including a copy of draft notifications to affected members and providers, sixty (60) days prior to the expected implementation of the change.

3.10.3. The request should contain, at a minimum, information regarding the:

- Nature of the operational change;
- Reason for the change;
- Methods of communication to be used; and
- Anticipated effective date.

3.10.4. If DHH does not respond to the CCN within thirty (30) days; the request and the notices are deemed approved.

3.10.5. A material change in CCN operations requires thirty (30) days advance written notice to affected providers and members.

3.10.6. The requirements regarding material changes to operations do not extend to Contract negotiations between the CCN and a provider.

3.10.7. CCNs may be required to conduct meetings with providers to address issues (or to provider general information, technical assistance, etc.) related to federal and state requirements, changes in policy, reimbursement matters, prior authorization and other matters as identified or requested by DHH.

3.11. Emergency Management Plan

3.11.1. The CCN shall submit an emergency management plan within forty-five (45) days from the date the Contract is signed to DHH for approval. The emergency management plan shall specify actions the CCN shall conduct to ensure the ongoing provision of health services in an epidemic, disaster or manmade emergency including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies. Revisions to the DHH approved emergency plan shall be submitted to DHH for approval no less than 30 days prior to implementation of requested changes. The CCN shall submit an annual certification (from the

date of the most recently approved plan) to DHH certifying that the emergency plan is unchanged from the previously approved plan.

3.11.2. At a minimum, the plan should include the following:

- Educating members and providers regarding hurricane preparedness and evacuation planning;
- Provide a CCN contact list (phone and email) for members/providers to contact to determine where healthcare services may be accessed/rendered;
- Identification of members with special healthcare needs who require evacuation assistance and informing local officials of those identified;
- MOUs with healthcare providers (especially hospitals and dialysis providers) in northern parishes for provision of services to evacuated members;
- MOUs PCPs in northern parishes that would allow evacuated providers to render services within their facilities;
- Registry of healthcare providers with PCP network (MD, nurse practitioner, etc.) who are willing to volunteer in state operated Special Needs shelters; and
- Use of EHR to provide healthcare providers access to member's health history and receive information of care provided during evacuation.

3.12. State and Federal Statues, Regulations and Administrative Procedures

The CCN shall comply with all current State and federal statutes, regulations, and administrative procedures that are or become effective during the term of this Contract. Federal regulations governing contracts with PCCM entities are specified in 42 CFR Part 438 and will govern this Contract. DHH is not precluded from implementing any changes in State or federal statutes, rules or administrative procedures that become effective during the term of this Contract and will implement such changes pursuant to § 19 of the RFP.

3.13. Hours of Operation

3.13.1. The CCN shall adhere to the following hours of operation:

3.13.1.1. Normal business hours which are Monday through Friday, 8 a.m. to 5 p.m., Central Time for general office based staffing.

3.13.1.2. Be operational on all Department regularly scheduled business days. A listing of holidays may be found at: http://www.civilservice.la.gov/OtherInfo/StateEmployeesInfo/bene%20HOLIDAYS.asp

3.13.1.3. Require providers to offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to non-Medicaid members.

3.13.1.4. Provide access within the CCN to primary care providers that offer extended office hours (minimum of 2 hours) at least one day per week (after 5:00 pm) and on Saturdays [four (4) hours or longer].

3.13.1.5. Ensure a toll-free number is available from 7 a.m. to 7 p.m. Central Time Monday through Friday for providers and members to access administrative components of the CCN's operations including, but not limited to, member services, requests for authorization, and for questions, concerns, complaints and request for PCP changes consistent with 42 CFR §438.6(k)(1).

3.14. Third Party Liability (TPL)

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 the CCN member. Under Section 1902(a)(25) of the Social Security Act, DHH is required to take all reasonable measures to identify legally liable third parties and treat third party liability as a resource of the Medicaid enrollee. The requirements for pursuing third party liability are found in 42 CFR §433 Subpart D.

DHH shall take responsibility for identifying and pursing TPL for CCN-S members, however the CCN has an affirmative duty to inform the DHH of any TPL coverage it has identified.

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4 CCN REIMBURSEMENT

DHH, or its fiscal intermediary, shall make monthly enhanced primary care case management fee payments to the CCN and lump sum savings payments to the CCN, if eligible. The enhanced primary care case management fee shall be based on the enrollee's Medicaid eligibility category as specified in this RFP and paid on a PMPM basis. The enhanced primary care case management rate schedule is provided in Appendix E – Mercer Certification, Rate Development Methodology and Rate). In order to be eligible to receive these payments, the CCN must enter into a Contract with DHH and remain in compliance with all provisions contained in the Contract.

The CCN shall agree to accept, as payment in full, the amount established by DHH pursuant to the Contract, and shall not seek additional payment from a member, or the Department, for any unpaid cost.

Claims payment for CCN members will continue to be paid by the FI through the fee-for-service system. After actual medical costs and the enhanced primary care case management fees are reconciled against the established per capita prepaid benchmark (PCPB), savings, if any, shall be shared between the CCN and DHH. Consistent with the approved 1932 State Plan Amendment, savings shared with the CCN are limited to five percent (5%) of the combined actual medical costs and the enhanced primary care case management fees.

The amount of shared savings for which the CCN is eligible is also contingent upon quality performance measure outcomes. If the aggregate of actual medical costs and enhanced primary care case management fees (excluding amounts paid to the PCPs) are greater than the PCPB, the CCN may be required to return up to fifty percent (50%) of the enhanced primary care case management fee payments.

DHH shall establish an enhanced primary care case management fee for the functions of enhanced primary care case management and PCP care management.

The enhanced primary care case management fee shall be an actuarially determined rate to be paid on a per member per month (PMPM) basis to the CCN for enhanced primary care case management services. The rates shall not be subject to negotiation.

The enhanced primary care case management fee rate will depend on the Medicaid eligibility group of the enrollee (e.g. Families/Children or SSI/Pregnant Women/Foster Children). (Appendix E – Mercer Certification, Rate Development Methodology and Rate). The PCP care management fee will

be paid to the PCP by the CNN for care management services (e.g. care coordination, referrals) for each member linked to the PCP.

The CCN is responsible to pay a minimum per member per month (PMPM) payment of the enhanced primary care case management fee to the PCP for his/her role in providing care management.

The PMPM rate will be prospectively paid on a PMPM basis; however, up to fifty percent (50%) is subject to repayment to DHH if a predetermined savings benchmark is not achieved in accordance to the terms of the Contract. The PMPM rate is intended to cover required enhanced primary care case management services under this RFP.

4.1. CCN Enhanced Primary Care Case Management Fee

The enhanced primary care case management fee provides for the functions of the enhanced primary care case management and PCP care management. The amount of the enhanced primary care case management fee will be dependent upon the eligibility category the individual is assigned by Medicaid (e.g. Families/Children or SSI/Pregnant Women/Foster Children). The rate will be prospectively paid on a PMPM basis; however, up to fifty percent (50%) is subject to repayment to DHH if a predetermined savings benchmark is not achieved.

4.2. CCN Enhanced Primary Care Case Management Fee Rate

The enhanced primary care case management fee rate shall depend on the Medicaid eligibility group of the enrollee. (See Appendix E - Mercer Certification, Rate Development Methodology and Rate)

4.3. PCP Care Management Fee

The CCN is responsible to pay a minimum amount of the PMPM of the enhanced primary care case management fee to the PCP for his/her role in providing care management. The PCP care management fee will be paid by the CCN to a PCP for care management services (e.g. care coordination, referrals) for each member linked to the PCP.

The CCN may reimburse each PCP an amount greater than but not less than that amount, unless mutually agreed upon by the PCP and the CCN. The CCN shall notify DHH of any downward adjustment in the PMPM PCP care management fee to the individual PCP. The difference in the agreed upon PMPM and the DHH specified PMPM shall be refunded to DHH. The CCN shall submit a

quarterly PCP Care Management Fee report to the Department, in the format specified in the ***CCN-S Systems Companion Guide***, detailing the amounts paid to the PCP..

In order to be eligible to receive the maximum agreed upon PCP PMPM payments, the PCP must enter into a subcontract with the CCN, meet performance measure goals and remain in compliance with all provisions contained in the subcontract. The CCN shall notify DHH of any reduction to the PCP's PMPM paid to the PCP due to non-compliance as specified.

The CCN shall not discriminate in the payment of the PCP care management fee and shall treat financially-related parties the same as non-financially related parties.

The CCN shall be liable to reimburse the predetermined PMPM PCP care management fee owed to the PCP(s) and all costs incurred to issue payments to the PCPs in the timelines specified by DHH for such reimbursement.

4.4. CCN Payment for Newborns and Deceased Members

The entire enhanced primary care case management fee payment will be paid during the month of birth and month of death. No proration adjustment to the enhanced primary care case management fee payments will occur to reflect eligibility for a partial month.

4.5. CCN Payment Schedule

The PMPM payment shall be based on member enrollment for the month and paid the payment cycle nearest the 1th calendar day of the month. Member enrollment for the month is determined by the total Medicaid eligibles assigned to the CCN as of the third (3rd) to last working day of the previous month. For age group assignment purposes, age will be defined as of the beginning of the month for which the payment is intended. The CCN shall make payments to its providers as stipulated in the Contract.

The CCN shall agree to accept payments as specified in this section and have written policies and procedures for receiving and processing PMPM payments and adjustments. Any charges or expenses imposed by a financial institution for transfers or related actions shall be borne by the CCN.

Section 6505 of the Affordable Care Act amends Section 1902(a) of the Social Security Act (the Act), and requires that a state shall not provide any payments for items or services provided under the State plan or under a waiver to any

financial institution or entity located outside of the United States (U.S.). This section of the Affordable Care Act is effective January 1, 2011, unless the Secretary determines that implementation requires State legislation, other than legislation appropriating funds, in order for the plan to comply with this provision. For purposes of implementing this provision, section 1101(a)(2) of the Act defines the term "United States" when used in a geographical sense, to mean the "States." Section 1101(a)(1) of the Act defines the term "State" to include the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, when used under Title XIX.

4.6. Payment Adjustments

In the event that an erroneous payment was made to the CCN, DHH shall reconcile the error by adjusting the CCN's next monthly enhanced primary care management fee payment.

- Retrospective adjustments to prior payments may occur when it is determined that a member's aid category is retroactively changed. Payment adjustments may only be made when identified within twelve (12) month from the date of the member's aid category change for all services delivered within the twelve (12) month time period.

- When a payment is made for a deceased member for a month after the month of death, DHH will recoup the payment.

4.7. Savings Determination

4.7.1. DHH will conduct periodic reconciliations to determine savings achieved or refunds due to DHH (from the enhanced primary care management fees). The reconciliation will compare the actual aggregate cost of authorized services as specified in this RFP, including the enhanced primary care management fee for dates of services in the reconciliation period, to the aggregate Per Capita Prepaid Benchmark (PCPB).

- The PCPB will not include the PCP care management fees described in § 4.3 above.

- In the event a member transitions from CCN mandatory or voluntary status to excluded status before being discharged from the hospital, the cost of the entire admission will be included in the actual cost when performing the savings reconciliation.

- Costs of DME and certain supplies, nursing home, dental, personal care services (EPSDT and LT), hospice, services provided by a school district and billed through the intermediate school district, EarlySteps services, targeted case management, non-emergency medical transportation, specific specialized behavioral health drugs, transplants, non-behavioral health drugs, and individual member total cost for the reconciliation year in excess of one hundred thousand dollars ($100,000), will not be included in the determination of the PCPB nor will it be included in actual cost at the point of reconciliation so that outlier cost of certain individuals and/or services will not jeopardize the overall savings achieved by the CCN.

- The PCPB benchmark for each CCN will be risk-adjusted, if applicable, according to the risk profiles of members enrolled with the CCN.

- DHH will perform interim and final reconciliations as of June 30th and December 31st of each year with provisions for Incurred-But-Not-Reported (IBNR) claims included in the actual cost. DHH reserves the right to make interim payments of any savings for any Dates of Service with more than 6 months elapsed time. A final reconciliation will be performed for any periods for which there are Dates of Service with more than 12 months elapsed time, at which point there should be sufficient completion of paid claims to determine total medical cost incurred by the CCN without the need to consider additional claims that have been incurred but are still outstanding. Final reconciliations will not be for less than 12 months (of service) unless determined appropriate by the Department.

- In the first year of a CCN's operations, DHH may exclude claims from the first 30 days of operations when calculating the reconciliation.

- In the event the CCN exceeds the PCPB in the aggregate (for the entire CCN enrollment), as calculated in the final reconciliation, the CCN will be required to refund up to 50% of the total amount of the enhanced care case management fees (excluding the PCP care management fee specified in §

4.3 above) paid to the CCN during the period being reconciled.

- Such amounts shall be determined in the aggregate, and not for separate enrollment types.

- CCN will be eligible for up to 60% of savings if the actual aggregate costs of authorized services, including enhanced primary care case management fees advanced, are less than the aggregate PCPB (for the entire CCN enrollment). The enhanced care management fee will be reduced by PCP PMPM during the reconciliation process. The PCP PMPM component of the enhanced care management fee will be in accordance with Appendix E –Mercer Certification, Rate Development Methodology and Rate. Due to limitations under the Medicaid State Plan, shared savings will be limited to 5% of the actual aggregate costs including the enhanced care management fees paid. Such amounts shall be determined in the aggregate, and not for separate enrollment types.

- During a CCN's first two years of implementation of the CCN Program, distribution of any savings will be contingent upon the CCN meeting the established "Early Warning System" administrative performance measures and compliance under this RFP. After the second year of implementation of the CCN Program, distribution of any savings will be contingent upon the CCN meeting established clinical performance measures and compliance with the Contract.

- The CCN will be responsible for dividing the CCN's share of savings (if applicable) between the participating providers and itself, based upon any agreement established between the CCN and the providers.

4.7.2. Health-Based Risk Adjustment Methodology

Health-based risk adjustment is a method that accounts for variation in health risks among participating CCNs when determining CCN-S shared savings. Risk adjustment provides a mechanism to better align the shared

savings per capita prepaid benchmark (PCPB) to the expected costs based on the health risk of the enrolled population.

The Adjusted Clinical Groups (ACGs) developed by Johns Hopkins University will initially be used to assess the health risk of each Medicaid/CHIP member and calculate the relative health risk of each CCN.

Using diagnoses reported on FFS claims along with age and gender, the ACG model assigns members into approximately one hundred (100) mutually exclusive groups or risk categories with a similar level of expected resource utilization. For each risk category, the cost weight or relative health risk score denoting the average costs of members relative to the overall population will initially be calculated using historical Louisiana specific experience from the fee-for-service Medicaid population.

The shared savings PCPB will be risk-adjusted by assessing the relative health risk of CCN members. The health risk will then be measured at the CCN level and will be used to adjust the universal PCPBs to arrive at the CCN-specific risk-adjusted PCPB. The risk-adjusted PCPB, in turn, will be used to determine the shared savings between the CCN and DHH. This will be accomplished by comparing the CCN-specific PCPB (adjusted to reflect the health risk of member enrollment) with the actual FFS medical costs for the measurement period.

Risk adjustment will begin three (3) months after initial program implementation. The PCPB for the initial three (3) months will be based entirely on the universal PMPM values. Starting in the fourth (4th) month of implementation in a geographic area, PCPBs will be risk-adjusted to applicable rate cells.

Assessment of individual member risk scores will be based on the most recent twelve months of complete fee-for-service claims data. The health risk of the members and the CCN will be updated on a semi-annual basis to reflect changes in risk over time.

4.8. Primary Care Provider Services Reimbursements

Enrollment in the Louisiana Medicaid Program is mandatory for all CCN network providers.

The CCN shall reimburse the PCP for PCP care management services. Claims payment for CCN members will continue to be paid by the FI through the fee-for-service system.

4.9. Return of Funds

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

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

4.10. Physician Incentive Plans

The CCN should develop incentive plans. All incentive plans for network providers shall be consistent with 42 CFR § 422.208 and 422.210 Physician incentive plans: requirements and limitations.

The CCN shall disclose to DHH the following:

- Services that are furnished by a physician/group that are covered by any incentive plan;
- Type of incentive arrangement, e.g. withhold, bonus, capitation;
- Percent of withhold or bonus (if applicable);
- Panel size, and if patients are pooled, the approved method used; and

- If the physician/group is at substantial financial risk, the entity must report proof the physician/group has adequate stop loss coverage, including amount and type of stop-loss.

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

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5 STAFF REQUIREMENTS AND SUPPORT SERVICES

The CCN shall have in place the organizational, operational, managerial and administrative systems capable of fulfilling all Contract requirements. For the purposes of this Contract, the CCN shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing [Executive Order 12549, 42 CFR 438.610(a) and (b), and 42 CFR §1001.1901(b)}, 42 CFR §1003.102(a)(2). The CCN must screen all employees and subcontractors to determine whether any of them have been excluded from participation in Federal health care programs. The HHS-OIG website can be searched by the names of any individuals and accessed at the following url: http://www.oig.hhs.gov/fraud/exclusions.asp

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

The CCN must obtain approval from DHH prior to moving functions outside the State of Louisiana. Such a request for approval must be submitted to the BHSF at least 60 days prior to the proposed changes in operations and must include a description of the processes in place that assure rapid responsiveness to effect changes for Contract compliance.

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

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

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

5.1. Minimum Staffing Requirements

At a minimum, the following staff is required:

a. **Administrator/CEO/COO** or their designee must be available during DHH working hours to fulfill the responsibilities of the position and to oversee the entire operation of the CCN. The Administrator shall devote sufficient time to the CCN's operations to ensure adherence to program requirements and timely responses to DHH. The Administrator or their designee shall participate in DHH's established committee for CCN administrative simplification.

b. **Medical Director/CMO** who is a physician with a current, unencumbered license through the Louisiana State Board of Medical Examiners. The Medical Director must have at least three (3) years of training in a medical specialty. The Medical Director shall devote full time (minimum 32 hours weekly) to the CCN's operations to ensure timely medical decisions, including after-hours consultation as needed. During periods when the Medical Director is not available, the CCN shall have physician staff to provide competent medical direction. The Medical Director shall be actively involved in all major clinical and quality management components of the CCN. The Medical Director shall be responsible for:

- Development, implementation and medical interpretation of medical policies and procedures including, but not limited to, service authorization, claims review, and referral management, and medical review included in the CCN Grievance System;

- Administration of all medical management activities of the CCN; and

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

c. **Chief Financial Officer/CFO** to oversee the budget, accounting systems and financial reporting implemented by the CCN.

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

e. **Grievance System Manager** who will manage and adjudicate member and provider disputes arising under the Grievance System including member grievances, appeals and requests for hearing and provider claim and disputes.

f. **Business Continuity Planning and Emergency Coordinator** to manage and oversee the CCN's emergency management plan during disasters and ensure continuity of core benefits and services for members who may need to be evacuated to other areas of the state or out-of-state.

g. **Contract Compliance Officer** who will serve as the primary point-of-contact for all CCN operational issues. The primary functions of the Contract Compliance Officer may include but are not limited to coordinate the tracking and submission of all Contract deliverables; field and coordinate responses to DHH inquiries, coordinate the preparation and execution of Contract requirements such as random and periodic audits and ad hoc visits.

h. **Information Management and Systems Director and Staff – Information Management and Systems Director and Staff –** An information systems director/manager shall be dedicated to the CCN program. The Information Management and Systems Director and staff shall be responsible for all CCN information systems supporting the Contract and shall be trained and experienced in information systems, data processing and data reporting as required to oversee all information systems functions supporting the Contract including, but not limited to, establishing and maintaining connectivity with DHH information systems and providing necessary and timely reports to DHH.

i. **Quality Management Coordinator** who is a Louisiana-licensed registered nurse, physician or physician's assistant or is a Certified Professional in Health Care Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers. The QM Coordinator must have experience

in quality management and quality improvement as specified in 42 CFR §438.200 – 438.242.

The primary functions of the Quality Management Coordinator position are:

- Ensure individual and systemic quality of care;
- Integrate quality throughout the organization;
- Implement process improvement;
- Resolve, track and trend quality of care grievances; and
- Ensure a credentialed provider network.

j. **Performance/Quality Improvement Coordinator** who has a minimum qualification as a CPHQ or CHCQM or comparable education and experience in data and outcomes measurement as specified in 42 CFR §438.200 – 438.242.

The primary functions of the Performance/Quality Improvement Coordinator are:

- Focus organizational efforts on improving clinical quality performance measures;
- Develop and implement performance improvement projects;
- Utilize data to develop intervention strategies to improve outcome; and
- Report quality improvement/performance outcomes.

k. **Material Child Health/EPSDT Coordinator** who is a Louisiana licensed nurse, physician, or physician's assistant; or has a Master's degree in health services, public health, or health care administration or other related field and/or a CPHQ or CHCQM. Staffing under this position should be sufficient to meet quality and performance measure goals.

The primary functions of the PSDT Coordinator are:

- Ensuring receipt of EPSDT services;
- Ensuring receipt of maternal and postpartum care;
- Promoting family planning services;
- Promoting preventive health strategies; and
- Identification and coordination assistance for identified member in need of EPSDT services.

l. **Medical Management Coordinator** who is a Louisiana-licensed registered nurse, physician or physician's assistant if required to make medical necessity determinations; or have a Master's degree in health services,

health care administration, or business administration if not required to make medical necessity determinations, who manages all required Medicaid management requirements under DHH policies, rules and Contract.

The primary functions of the Medical Management Coordinator are:

- Ensure adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria;
- Ensure appropriate concurrent review and discharge planning of inpatient stays is conducted;
- Develop, implement and monitor the provision of care coordination, disease management and case management functions;
- Monitor, analyze and implement appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services; and
- Monitor prior authorization functions and assure that decisions are made in a consistent manner based on clinical criteria and meet timeliness standards.

m. **Member Services Manager and Staff** to coordinate communications between the CCN and its members. There shall be sufficient Member Services staff to enable members to receive prompt resolution of their problems or inquiries and appropriate education about participation in the CCN program.

n. **Provider Services Manager and Staff** to coordinate communications between the CCN and its subcontracted providers. There shall be sufficient Provider Services staff to enable providers to receive prompt resolution of their problems or inquiries and appropriate education about participation in the CCN program and to maintain a sufficient provider network.

o. **Claims Administrator** to develop, implement and administer a comprehensive claims pre-processing system which collects claims, verifies eligibility, validates prior authorization, pre-processes, and submit claims data to DHH's FI that complies with state and federal requirements.

The primary functions of the Claims Administrator are:

- Develop and implement claims pre-processing systems capable of pre-processing claims in accordance with state and federal requirements and the terms of the Contract;
- Develop processes for cost avoidance;
- Meet claims pre-processing timelines; and
- Meet DHH claims data requirements.

p. **Provider Claims Educator** (full-time equivalent employee for a CCN with over 100,000 members statewide)The position is fully integrated with the CCN's grievance, claims pre-processing, and provider relations systems and facilitates the exchange of information between these systems and providers, with a minimum of five years management/supervisory experience in the health care field.

The primary functions of the Provider Claims Educator are:

- Educate subcontracted and non-contracted primary care providers regarding appropriate claims submission requirements, coding updates, electronic claims and available CCN resources such as provider manuals, website, fee schedules, etc.;
- Interface with the CCN's call center to compile, analyze, and disseminate information from provider calls;
- Identify trends and guide the development and implementation of strategies to improve provider satisfaction; and
- Frequently communicates (i.e., telephonic and on-site) with providers to assure the effective exchange of information and gain feedback regarding the extent to which providers are informed about appropriate claims submission practices.

q. **Case Management Administrator/Manager** to oversee the case management functions and who shall have the qualifications of a case manager (See definitions) and a minimum of 5 years of management/supervisory experience in the health care field.

r. **Prior Authorization Staff** to make authorization decisions for health care services 24 hours per day, 7 days per week. This staff shall be available 24/7 and include a Louisiana licensed registered nurse, physician or physician's assistant; who work under the direction of a Louisiana-licensed registered nurse, physician or physician's assistant.

s. **Clerical and Support Staff** to ensure proper functioning of the CCN's operation.

t. **Claims Pre-Processing Staff** to ensure the timely and accurate pre-processing of original claims, resubmissions and overall adjudication of claims.

u. **Case Managers** to assess, plan, facilitate and advocate options and services to meet the enrollee's health needs through communication and available resources to promote quality cost-effective outcomes.

5.2. **Reporting**

5.2.1. The CCN must submit to the Medicaid Coordinated Care Section the following items annually:

a. An organizational chart with the "key personnel" positions. The chart must include the person's name, title and telephone number and portion of time allocated to each Medicaid contract and other lines of business.

b. A functional organization chart of the key program areas, responsibilities and the areas which report to that position.

c. A listing of all functions and their locations; and a list of any functions that have moved outside of the State of Louisiana in the past contract year.

5.2.2. The positions described in § 5.3.1 above represent the minimum management staff requirements for the CCN. The CCN shall report changes in management staff to DHH within five (5) business days of the change.

5.3. **Key Personnel**

5.3.1. An individual staff member is limited to occupying a maximum of two of the Key Staff positions listed below unless prior approval is obtained by DHH or otherwise stated below.

5.3.2. The CCN may terminate any of its employees designated to perform work or services under this contract, as permitted by applicable law.

5.3.3. The CCN shall inform the DHH in writing within seven days, when an employee leaves one of the **Key Personnel** positions listed below (this requirement does not apply to Additional Required Staff, also listed below). The name of the interim contact person should be included with

the notification. The CCN shall replace any of the key staff with a person of equivalent experience, knowledge and talent. The name and resume of the permanent employee should be submitted as soon as the new hire has taken place along with a revised Organization Chart complete with Key Staff time allocation.

5.3.4. Replacement of the Administrator/CEO/COO or Medical Director/CMO shall require or prior written approval from DHH which will not be unreasonably withheld provided a suitable candidate is proposed.

5.3.5. Annually, the CCN must provide the name, Social Security Number and date of birth of the staff members performing the duties of the Key Staff listed as §5.3.5 below. DHH will compare this information against federal databases to confirm that those individuals have not been banned or debarred from participating in Federal programs [42CFR 455.104].

5.3.6. Key personnel shall be defined as:

- Administrator/CEO/COO
- Medical Director/CMO
- Chief Financial Officer
- Compliance Officer
- Business Continuity Planning and Emergency Coordinator
- Contract Compliance Officer
- Information Management and Systems Director
- Grievance System Manager
- Contract Compliance Officer
- Quality Management Coordinator
- Maternal Health/EPSDT (Child Health) Coordinator
- Medical Management Coordinator
- Members Services Manager
- Provider Services Manager
- Provider Claims Educator
- Case Management Administrator/Manager

5.3.7. The CCN is responsible for maintaining a significant local (within the State of Louisiana) presence. Positions specified below should be located within the State:

- Administrator/CEO/COO
- Medical Director/CMO
- Compliance Officer

- Business Continuity Planning and Emergency Coordinator
- Contract Compliance Officer
- Grievance System Manager
- Quality Management Coordinator
- Maternal Health/EPSDT (Child Health) Coordinator
- Medical Management Coordinator
- Member Services Manager
- Provider Services Manager
- Provider Claims Educator
- Case Management Administrator/Manager

5.4. Staff Training and Meeting Attendance

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

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

New and existing prior authorization and member services representatives must be trained in the geography of any/all GSA(s) in which the CCN holds a contract and have access to mapping search engines (e.g. MapQuest, Yahoo Maps, Google Maps, etc) for the purposes of authorizing services in; and recommending providers in the most geographically appropriate location.

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

DHH reserves the right to attend any and all training programs and seminars conducted by the CCN. The CCN shall provide DHH a list of any marketing training dates (See §7 Marketing and Outreach), time and location, at least fourteen (14) calendar days prior to the actual date of training.

5.5. Written Policies, Procedures and Job Descriptions

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

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

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6 PROVIDER NETWORK

The CCN must provide a comprehensive primary care network to ensure its membership has access at least equal to, or better than community norms. Services shall be accessible to CCN members in terms of timeliness, amount, duration and scope as those are available to Medicaid recipients within the same GSA who are not enrolled in the CCN Program. The CCN is encouraged to have available non-emergent after-hours physician or primary care services within its network. If the network is unable to provide medically necessary services required under Contract, the CCN shall ensure timely and adequate coverage of these services through an out-of-network provider until a network provider is contracted. The CCN is responsible for covering services related to the following:

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

The CCN is expected to design a network that provides a geographically convenient flow of patients among network providers. The provider network shall be designed to reflect the needs and service requirements of the CCN's member population.

There shall be sufficient personnel for the provision of all enhanced primary care case management services.

6.1. Significant Traditional Providers

The CCN shall make a good faith effort to include in its network significant traditional providers (STPs) in its GSA for the first two (2) years of operation under the CCN Contract; provided the STP agrees to participate as an in-network provider and abide by the provisions of the provider subcontract with the CCN. In the event an agreement cannot be reached and an entity does not participate in the CCN, the CCN shall maintain documentation detailing efforts which were made. This requirement does not prohibit the CCN from limiting provider participation to the extent necessary to meet the needs of the CCN members. This requirement does not interfere with measures established by the CCN to control costs and quality consistent with its responsibilities under this contract.

6.2. Network Provider Development and Management Plan

The CCN shall develop and maintain a Primary Care Network Provider Development and Management Plan which ensures access to primary care services and PCP case management services. The Network Development and Management Plan shall be evaluated, updated annually and submitted to DHH within thirty (30) days from the date the Contract with DHH is signed by the CCN and annually thereafter. The submission of the Network Management and Development Plan to DHH is an assurance of the adequacy and sufficiency of the CCN's primary care provider network. The CCN shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services.

In accordance with the requirements in this RFP, and the members' needs, the proposed network shall be sufficient to provide core benefits and services within designated time and distance limits. The Network Provider Development and Management Plan shall identify gaps in the CCN's provider network and describe the process by which the CCN shall assure all covered services are delivered to CCN members. Planned interventions to be taken to resolve such gaps shall also be included.

The CCN must maintain and monitor a primary care provider network that is supported by written agreements and is sufficient to meet the minimum capacity requirements set forth in §3 of this RFP. When designing this network, the CCN must take into consideration all the requirements specified in this RFP's terms and conditions. This includes access standards and guidelines for delivery of primary care services. The CCN PCPs shall comply with all requirements set forth in this RFP.

6.2.1. The CCN shall provide GEO mapping and coding of all PCPs by provider type by the deadline date specified in the Schedule of Events to geographically demonstrate capacity. The CCN shall provide updated GEO coding to DHH quarterly, or upon material change (as defined in the Glossary) or upon request.

6.2.2. The CCN shall develop and implement Network Development and Management policies and policies detailing how the CCN will [42 CFR 438.214(a)]:

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

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

6.2.2.3. Evaluate the quality of services delivered by the network;

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

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

6.2.2.6. Contract with providers in a manner that incorporates quality management, utilization, office audits and provider profiling;

6.2.2.7. Provide training for its PCPs and maintain records of such training;

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

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

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

6.2.4. CCN Network Development and Management policies shall be subject to approval by DHH, Medicaid Coordinated Care Section and shall be monitored through operational audits.

6.3. Manner of Service Delivery and Provision

In establishing and maintaining the PCP network, the CCN shall consider the following:

- The maximum Medicaid enrollment capacity;
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations enrolled in the CCN;
- The number of network providers who are not accepting new Medicaid patients; and
- The geographic location of providers and Medicaid members; considering distance travel time, and means of transportation ordinarily used by Medicaid members.
- All providers shall be in compliance with American with Disabilities Act (ADA) requirements and provide physical access for Medicaid members with disabilities.
- The CCN shall allow female members direct access to a women's health specialist for Louisiana Medicaid State Plan services necessary to provide women's routine and preventive health care services. This is in addition to the members designated source of primary care if that source is not a women's health specialist.

6.4. Mainstreaming

6.4.1. DHH considers mainstreaming of CCN members into the broader health delivery system to be important. The CCN therefore must ensure that all CCN providers accept members for treatment and

that CCN providers do not intentionally segregate members in any way from other persons receiving services.

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

- Denying or not providing to a member any covered service or availability of a facility.
- 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.
- Discriminatory practices with regard to members such as separate waiting rooms, separate appointment days, or preference to private pay or Medicaid fee-for-service patients.

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

6.5. Primary Care Providers (PCP)

A PCP in the CCN must be a provider who provides or arranges for the delivery of medical services, including case management which are found to be medically necessary, are made available in a timely manner as outlined in this RFP.

Each Medicaid potential enrollee shall be given the opportunity to choose between CCNs, and to choose a specific PCP within the CCN's provider network, that will be responsible for the provision of primary care services and the coordination of all other health care needs. Medicaid eligibles that are unable or unwilling to make a choice of CCN at the point of completing the Medicaid or CHIP application form shall be contacted by DHH's Enrollment Broker to assist the individual in choosing a CCN. The Enrollment Broker shall assign a CCN to a Medicaid potential enrollee/enrollee if the potential enrollee/enrollee fails to select a CCN within the established timeframe or after a change in CCN has occurred.

The PCP selected for the CCN member should be a provider that is located geographically close to the CCN member's home, and/or best meets the needs of the member. However, the CCN member has the freedom to request a change of primary care provider within the CCN anytime within the first 90 days of assignment.

The CCN shall identify and report to the Enrollment Broker within seven (7) calendar days any PCP approved to provide services described within this RFP who will not accept new patients or has reached capacity.

The PCP shall serve as the member's initial and most important point of interaction.

6.6. PCP Responsibilities

6.6.1. The PCP responsibilities shall include, but not be limited to:

- Managing the medical and health care needs of members to assure that all medically necessary services are made available in a timely manner;
- Monitoring and follow-up of care provided by other medical service providers for diagnosis and treatment;
- Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through fee-for-service Medicaid;
- Maintaining a medical record of all services rendered by the PCP and other referral providers.

- Providing for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions;

- Providing case management services to include, but not be limited to, screening and assessment, development of a treatment plan of care to address risks and medical needs and other responsibilities as defined in the Contract;

- Prohibiting discrimination in enrollment, disenrollment, and re-enrollment, based on the recipient's health status or need for health care services.

6.6.2. Examples of Acceptable PCP After-Hours Coverage

- The PCP's office telephone is answered after-hours by an answering service, can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes;

- The PCP's office telephone is answered after normal business hours by a recording directing the member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable; and

- The PCP's office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.

6.6.3. Examples of Unacceptable PCP After-Hours Coverage

- The office telephone is only answered during office hours;

- The office telephone is answered after-hours by a recording that tells patients to leave a message;

- The office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed; and

- Returning after-hours calls outside of 30 minutes.

6.7. Adequacy of Network Provider

6.7.1. The CCN shall maintain appropriate levels of primary care providers for the provision of services within the each GSA to insure that all required core benefits and services are available and accessible in a timely manner in accordance with this RFP. The CCN shall enter into contracts with a sufficient number of PCPs to ensure adequate accessibility and sustainability for members in compliance with 42 CFR §438.206.

6.7.2. The locations of primary care providers must be sufficient in terms of geographic convenience to CCN members.

6.7.3. The CCN shall notify DHH immediately of any changes to the composition of its provider network that materially and/or adversely affects its ability to make available all primary care services and care management services in a timely manner in accordance with this RFP.

6.7.4. The CCN shall have procedures to address changes in its provider network that negatively affect the ability of CCN members to access services. Material changes in provider network composition that are not prior approved by DHH and/or that may impair the CCN member's access to services will be considered as grounds for sanctions, including but not limited to, termination of Contract. The CCN understands and agrees that notwithstanding the execution of this Contract, neither the CCN nor its contractor/network provider shall provide any services to a CCN member until the CCN has an adequate provider network verified and approved by DHH. Enrollees must receive written notice within thirty (30) days of any material change in provider network before the intended effective date of the change.

6.7.5. In the event a CCN is found to be in violation of the requirements stated in this section, DHH reserves the right to implement the CCN Turnover Plan or other sanctions, as described in this RFP.

6.7.6. DHH may also, at its sole discretion, suspend any new enrollments in the CCN, including auto-enrollments, in the affected GSA during the Transition period (see Appendix AA Transition Period

Requirements)or until the CCN has demonstrated that it will be able to maintain its services in their designated GSA.

6.7.7. The CCN shall at least quarterly validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted providers and provide verification to DHH. Failure to do so may result in monetary penalties up to $5,000 per day against the CCN.

6.8. Material Change in Provider Network

6.8.1. All material changes in the CCN's provider network must be approved in advance by DHH, BHSF/Medicaid Coordinated Care Section.

6.8.2. A material change to the provider network is defined as one which affects, or can reasonably be foreseen to affect, the CCN's ability to meet the performance and network standards as described in this Contract. It also includes any change that would cause more than 5% of members in the GSA to change the location where services are received or rendered.

6.8.3. The CCN must submit the request for approval of a material change in their provider network, including copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.

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

6.8.5. If DHH does not respond within thirty (30) days the request and the notice are deemed approved.

6.8.6. A material change in the CCN's provider network requires thirty (30) days advance written notice to affected members. For emergency situations, DHH will expedite the approval process.

6.8.7. The CCN shall notify DHH/BHSF/Medicaid Coordinated Care Section within one (1) business day of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, a provider dies, the provider moves from the service area and fails to notify the CCN, or is displaced as a result

of a natural or man-made disaster) that would impair its provider network [42 CFR 438.207(c)].

6.8.8. This notification shall include:

- Information about how the provider network change will affect the delivery of core benefits and services, and
- The CCN's plans for maintaining the quality of member care, if the provider network change is likely to affect the delivery of core benefits and services.
- CCNs shall give hospitals and provider groups ninety (90) days notice prior to a contract termination without cause.
- Contracts between the CCN and single practitioners are exempt from this requirement.

6.9. Patient-Centered Medical Home

The CCN will promote and facilitate the capacity of all PCP practices to meet the recognition requirements of a NCQA PPC®-PCMH™ as jointly defined by NCQA or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Primary Care Home Accreditation and DHH.

The CCN shall report those primary care provider practices that achieve recognition or meet the requirements of the National Committee for Quality Assurance (NCQA) for PPC®-PCMH™ or JCAHO Primary Care Home Accreditation. The CCN shall ensure thresholds and timetables are met for the establishment of PCP practice NCQA PPC®-PCMH™ recognition, Levels 1-3 or JACHO Primary Care Home Accreditation, and as defined in the terms and conditions of this RFP.

6.9.1. The CCN shall provide a PCMH Implementation Plan within ninety (90) days of the "Go Live" date that identifies the methodology for promoting and facilitating PPC®-PCMH recognition and/or JCAHO PCH accreditation. The implementation plan shall include, but not be limited to:

- Payment methodology for payment to primary care practices for the specific purpose of supporting necessary costs to transform and sustain NCQA PPC®- PCMH recognition or JCAHO PCH accreditation through enhanced payment or

performance based incentives for achieving the necessary parameters;

- Provision of technical support, to assist in their transformation to PPC®-PCMH recognition or JCAHO PCH accreditation(e.g., education, training, tools, and provision of data relevant to patient clinical care management);

- Facilitation of specialty provider network access and coordination to support the PCMH; and

- Facilitation of data interchange between PCMH practices, specialists, labs, pharmacies, and other providers.

6.9.2. The CCN shall meet or exceed the following thresholds and timetables for primary care practices to achieve NCQA PPC®-PCMH recognition or JCAHO PCH accreditation:

6.9.2.1. By the end of the first year of operations in the region:

- Total of 20% of practices shall be NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited.

6.9.2.2. By the end of the second year of operation under the Contract:

- Total of 30% of practices shall be NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited; and

- Total of 10% of practices shall be NCQA PPC®-PCMH Level 2 recognized or JCAHO PCH accredited.

6.9.2.3. By the end of the third year of operation under the Contract:

- Total of 10% of practices shall be NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited;

- Total of 40% of practices shall be NCQA PPC®-PCMH Level 2 recognized or JCAHO PCH accredited; and

- Total of 10% of practices shall be NCQA PPC®-PCMH Level 3 recognized or JCAHO PCH accredited.

6.9.3. The CCN shall submit an annual report indicating PCP practices that are NCQA PPC®-PCMH recognized, including the levels of recognition, or JCAHO PCH accreditation. Nurse practitioner-led practices may meet NCQA PPC®-PCMH Level 1 recognition requirements and notify the CCN, via attestation and supporting documentation, of the level achieved. The CCN may include these practices, and identify in reporting, the number of these practices that have met NCQA PPC®-PCMH Level 1 requirements.

6.9.4. The CCN shall participate in Patient-Centered Primary Care Collaborative activities.

6.9.5. Subsequent renewal of the Contract beyond the initial three year period will require increased percentage of PCP practices to be NCQA recognized or JCAHO accredited to a total of eighty (80%) of practices.

6.9.6. The CCN shall report those primary care provider practices that achieve recognition or meet the requirements of the National Committee for Quality Assurance (NCQA) for PPC®-PCMH™ or JCAHO Primary Care Home Accreditation. The CCN shall ensure thresholds and timetables are met for the establishment of PCP practice NCQA PPC®-PCMH™ recognition, Levels 1-3 or JACHO Primary Care Home Accreditation, and as defined in the terms and conditions of this RFP.

6.10. Local Public Health Agencies

The CCN should coordinate its public health-related activities with OPH. Coordination mechanisms and operational protocols for addressing public health issues will be negotiated with OPH and BHSF (Medicaid) and reflect Louisiana public health priorities. The coordination of activities related to public health will take the form of agreements among the parties which may include policy memos or separate memorandums of

understanding signed by OPH, BHSF (Medicaid), and the CCN. (See Appendix II)

6.11. Federal Quality Health Centers (FQHC) /Rural Health Clinics (RHC) Contracting Requirements

6.11.1. The CCN shall offer a Contract to all Federally Qualified Health Centers and, where applicable, Rural Health Clinics (free standing and hospital-based) in its GSA.

- If an agreement cannot be reached with a FQHC/RHC, the CCN shall inform DHH and the CCN is not required to provide access to primary care services provided by the FQHC/RHC except in the following cases:
  - The medically necessary services are required to treat an emergency medical condition; or
  - FQHC/RHC services are not available through CCNs (CCN-P or CCN-S) in the geographic service area within DHH's established time and distance travel standards.

6.11.2. The CCN must explicitly identify and inform potential enrollees and members the availability on FQHC/RHC services and limitation on access to those services.

The CCN shall inform members of this right in their member handbooks.

6.11.3. The CCN shall have written procedures for promptly transferring medical information needed for coordinating care with a FQHC. CCNs shall expect a sharing of information and data and appropriate CCN referrals from non-network FQHCs.

6.12. School Based Health Clinics (SBHC)

SBHC (certified by the DHH Office of Public Health) services are those Medicaid services provided within school settings to Medicaid eligible children under the age of 21.

The CCN must make a good faith effort to collaborate with SBHCs in their GSAs. The CCN may stipulate that the SBHC follow all of the CCN's required policies and procedures.

For those SBHCs that meet the criteria to become a primary care provider the CCN must offer a Contract and may require the SBHC to meet the same terms and conditions as other primary care providers.

6.13. Subcontracting Requirements

The CCN shall provide enhanced primary care case management services specified in this RFP. The CCN may provide these services directly or may enter into subcontracts with entities that will authorize specified Medicaid State Plan services and provide care management to the members. The provision of Medicaid State Plan services will be delivered by the Louisiana Medicaid FFS provider network. Claims will be pre-processed by the CCN and paid by the State's FI. The CCN is ultimately responsible for all requirements of the Contract, including those performed by the CCN subcontractor(s).

Any plan to delegate enhanced primary care management responsibilities of the CCN to a subcontractor shall be approved by DHH.

Model subcontracts for care management providers shall be submitted within thirty (30) days after the Contract is signed by the CCN.

After the execution of the Contract, the CCN shall submit to DHH for review and approval, prior to execution of the subcontract, any subcontract that is materially different from the model contract already approved by DHH for care management providers. DHH shall have the right to review and approve any and all subcontracts entered into for the provision of any activities under this RFP. The turnaround time for approval is expected to be thirty (30) days or less. Notification of amendments or changes to any contract which materially affects the subcontract, shall be provided to DHH prior to the execution of the amendment in accordance with §19.33 of this RFP.

The CCN shall not execute subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§ 1128 (42 U.S.C. 1320a-7) (2001, as amended) or 1156 (42 U.S.C. 1320 c-5) (2001, as amended) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. The CCN shall not enter into any relationship with anyone

debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

6.13.1. Required Terms and Conditions for Subcontracts

All subcontracts executed by the CCN pursuant to this section shall, at a minimum, include the following terms and conditions and no other terms and conditions agreed to by the CCN and its subcontractor shall negate or supersede the requirements in this RFP:

6.13.1.1. Contain language that the subcontractor shall adhere to all requirements set forth for CCN subcontractors in the Contract between DHH and CCN and department issued Guides; and either physically incorporating these document as appendices to the subcontract or include language in the subcontract that the CCN shall furnished these documents to the provider upon request.

6.13.1.2. Include a signature page which contains a CCN and provider name which are typed or legibly written, provider company with titles, and dated signature of all appropriate parties; (applicable for renewals as well). All subcontracts must be in writing and signed by the CCN and subcontractor.

6.13.1.3. Specify the effective dates of the subcontract agreement.

6.13.1.4. Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.

6.13.1.5. Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties, however

the CCN may provide amendments by written notification through the CCN bulletin board, if mutually agreed to in terms of the subcontract and with prior notice to DHH.

6.13.1.6. Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract; however the CCN may provide amendments by written notification through CCN bulletins, if mutually agreed to in terms of the contract and with prior notice to DHH.

6.13.1.7. Specify that the CCN and subcontractor recognize that in the event of termination of the Contract between the CCN and DHH for any of the reasons described in the Contract, the CCN shall immediately make available, to DHH, or its designated representative, in a usable form, any and all records, whether medical or financial, related to the CCN's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to DHH.

6.13.1.8. Assure the subcontractor shall not, without prior approval of the CCN, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the CCN.

6.13.1.9. Require that if any requirement in the subcontract is determined by DHH to conflict with the subcontract between DHH and the CCN, such requirement shall be null and void and all other provisions shall remain in full force and effect.

6.13.1.10. Identify the population covered by the subcontract.

6.13.1.11. Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor shall provide these services to members through the last day that the subcontract is in effect. All final Medicaid benefit determinations are within the sole and exclusive authority of DHH or its designee.

6.13.1.12. Specify that the subcontractor may not refuse to provide medically necessary or core preventive benefits and services to CCN members specified under the Contract between DHH and the CCN for non-medical reasons (except those services allowable under federal law for religious or moral objections).

6.13.1.13. Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the CCN.

6.13.1.14. Specify the amount, duration and scope of core benefits and services as specified in the Louisiana Medicaid State Plan that are provided by the subcontractor, including all specific requirements outlined in the RFP and department issued Guides.

6.13.1.15. Provide that emergency services be coordinated without the requirement of prior authorization of any kind.

6.13.1.16. Specify that the provider may not refuse to provide covered medically necessary or

covered preventative services to members for non-medical reasons. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship.

6.13.1.17. Include a provision which states the subcontractor is not permitted to encourage or suggest, in any way, that members be placed in state custody in order to receive medical or specialized behavioral health services covered by DHH.

6.13.1.18. Require that an adequate record system be maintained for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to CCN members pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the Contract between DHH and the CCN). CCN members and their representatives shall be given access to and can request copies of the members' medical records, to the extent and in the manner provided by LRS 40:1299.96 and 45 CFR 164.524 as amended and subject to reasonable charges.

6.13.1.19. Include medical record requirements as specified in the Contract between DHH and the CCN.

6.13.1.20. Require that any and all member records including but not limited to administrative, financial, and medical be retained (whether electronic or paper) for a period of six (6) years after the last payment was made for services provided to a member and retained further if the records are under review, audit, or related to any matter in litigation until the review,

audit, or litigation is complete. The exception to this requirement shall include records pertaining to once-in-a-lifetime events such as but not limited to appendectomy and amputations etc.) which must be retained indefinitely and may not be destroyed. This requirement pertains to the retention of records for Medicaid purposes only; other state or federal rules may require longer retention periods. Current State law (La. R.S. 40:1299.96) requires physicians to retain their records for at least six (6) years. These minimum record keeping periods commence from the last date of treatment. After these minimum record-keeping periods, state law allows for the destruction of records. Said records shall be made available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of an authorized representative of DHH.

6.13.1.21. Provide that DHH, U.S. Department of Health and Human Services (HHS), CMS, Office of Inspector General Comptroller, State Legislative Auditor's Office, and the Louisiana Attorney General's Office shall have the right to evaluate through audit, inspection, or other means, whether announced or unannounced, any records pertinent to the Contract between DHH and the CCN, including quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and practitioner claims submitted to the CCN. Such evaluation, when performed, shall be performed with the cooperation of the CCN. Upon request, the CCN shall assist in such reviews.

6.13.1.22. Require the subcontractor comply and submit to the CCN disclosure of information in accordance with the requirement specified in 42 CFR §455, Subpart B.

6.13.1.23. Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the CCN and/or DHH or its designee.

6.13.1.24. Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the CCN/subcontractor practices and/or the standards established by DHH or its designee.

6.13.1.25. Require that the subcontractor comply with any corrective action plan initiated by the CCN and/or required by DHH.

6.13.1.26. Specify any monetary penalties, sanctions or reductions in payment that the CCN may assess on the provider for specific failures to comply with subcontractual and/or credentialing requirements. This shall include, but may not be limited to a provider's failure or refusal to respond to the CCN's request for information, the request to provide medical records, credentialing information, etc.; at the CCN's discretion or a directive by DHH, the CCN shall impose at a minimum, financial consequences against the provider as appropriate.

6.13.1.27. Provide for submission of all reports and clinical information required by the CCN for reporting purposes such as HEDIS, AHRQ, and EPSDT.

6.13.1.28. Require safeguarding of information about CCN members according to applicable state and federal laws and regulations and as

described in Contract between DHH and the CCN.

6.13.1.29. Provide the name and address of the official payee to whom payment shall be made.

6.13.1.30. Make full disclosure of the method and amount of compensation or other consideration to be received from the CCN.

6.13.1.31. Provide for prompt submission of complete and accurate claims information needed to make payment.

6.13.1.32. Provide that subcontractors must submit all clean claims for payment no later than twelve (12) months from the date of service.

6.13.1.33. Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold DHH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Contract between DHH and the CCN, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the Contract between DHH and the CCN in its entirety in the subcontractor's agreement or by use of other language developed by the CCN and approved by DHH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by DHH.

6.13.1.34. Require the subcontractor to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the CCN's members and the CCN under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall

furnish the CCN with written verification of the existence of such coverage.

6.13.1.35. Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services under the CCN Program.

6.13.1.36. Provide that the subcontract incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective. In the event that changes in the subcontract as a result of revisions and applicable federal or state law materially affect the position of either party, the CCN and subcontractor agree to negotiate such further amendments as may be necessary to correct any inequities.

6.13.1.37. Specify that the CCN and subcontractor recognize that in the event of termination of the Contract between the CCN and DHH for any of the reasons described in Contract between the CCN and DHH, the CCN shall immediately make available, to DHH, or its designated representative, in a usable form, any and all records, whether medical or financial, related to the CCN's and its subcontractor's activities undertaken pursuant to the subcontract. The provision of such records shall be at no expense to DHH.

6.13.1.38. Provide that the CCN and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the CCN member.

6.13.1.39. Include a conflict of interest clause as stated in the Contract between DHH and the CCN.

6.13.1.40. Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined in this RFP and Quality Companion Guide. The QAPI and UM requirements shall be included as part of the subcontract between the CCN and the subcontractor.

6.13.1.41. Provide that all subcontractors shall give CCN immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the CCN.

6.13.1.42. Contain no provision which provides incentives, monetary or otherwise, for the withholding of medically necessary care.

6.13.1.43. Specify that the subcontractor shall not assign any of its duties and/or responsibilities as required in the Contract between DHH and the CCN without the prior written consent of the CCN.

6.13.1.44. Specify that the CCN shall not prohibit or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient {1932(b)(3(D), 42 CFR §438.102(a)(1)(i),(ii),(iii) and (iv)}: a) for the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; b) for any information the enrollee needs in order to decide among all relevant treatment options; c) for the risks, benefits, and consequences of treatment or non-treatment; and d) for the enrollee'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.

6.13.1.45. Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.

6.13.1.46. Contain no provision which restricts a subcontractor from subcontracting with another CCN or other managed care entity.

6.13.1.47. Provide that all records originated or prepared in connection with the subcontractor's performance of its obligations under the subcontract, including but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by the subcontractor in accordance with the terms and conditions of the Contract between DHH and the CCN. The subcontract must further provide that the subcontractor agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of members relating to the delivery of care or service under the Contract between DHH and the CCN and as further required by DHH, for a period of six (6) years from the expiration date of the Contract between DHH and the CCN, including any Contract extension(s). If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of

all issues which arise from it or until the end of the six (6) year period, whichever is later. If the subcontractor stores records on microfilm or microfiche or other electronic means, the subcontractor must agree to produce, at its expense, legible hard copy records upon the request of state or federal authorities, within twenty-one (21) calendar days of the request.

6.13.1.48. State that in accordance with 42 CFR §438.210(e) compensation to the CCN or individuals that conduct utilization management activities is not structured so as to provide incentives for the individual or CCN to deny, limit, or discontinue medically necessary services to any member.

6.13.1.49. Provide that subcontractors, as applicable, register all births through LEERS (Louisiana Electronic Event Registration System) administered by DHH/Vital Records Registry.

6.13.1.50. Provide that PCP's subcontract specify the maximum number of linkages the CCN may link to the PCP. The subcontract shall also stipulate that by signing the subcontract the PCP confirms that the PCP's total number of Medicaid members for the CCN Program will not exceed 2,500 lives.

6.14. Provider-Member Communication Anti-Gag Clause

6.14.1. Subject to the limitations described in 42 §1932(b)(3)(D), the CCN shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the Contract, for the following:

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

6.14.2. Any CCN that violates the anti-gag provisions set forth in 42 U.S.C §1932(b)(3)(D) shall be subject to intermediate sanctions.

6.14.3. The CCN shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans.

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

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

6.14.6. The CCN shall identify deficiencies or areas for improvement, and take corrective action.

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7 ENHANCED PRIMARY CARE CASE MANAGEMENT SERVICES

The CCN shall possess the expertise and resources to ensure the delivery of enhanced primary care case management and PCP care management services to CCN members in accordance with the provisions of this RFP, and Medicaid rules and regulations (See Appendix CC – ePCCM Breakdown of Tasks). These services shall include, but not be limited to, referral to and coordination of authorized services to any of the Medicaid providers where a referral has been made; chronic care management; member services, and quality management.

7.1. Care Management

Care management is defined as the overall system of medical management encompassing, but not limited to, Referrals, Utilization Management, Case Management, Care Coordination, Continuity of Care, Care Transition Chronic Care Management, and Independent Review. The CCN shall ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating Medicaid authorized services provided to the member. The CCN shall be responsible for ensuring:

- Member's health care needs and services are planned and coordinated through the CCN PCP;
- Accessibility of services and promoting prevention through qualified medical home practices in accordance with 42 CFR § 438.6 (k) which requires the provision for reasonable and adequate hours of operation including 24/7 availability of information, referral, and treatment for emergency medical conditions; and
- Care coordination and referral activities, incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services without compromise to quality of care. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical and/or behavioral health services.

7.1.1. Referrals

The CCN shall have a referral system for CCN members requiring specialty health care services to ensure that services can be furnished to enrollees promptly and without compromise to care.

The CCN shall provide the coordination necessary for referral as appropriate, of CCN members to, including but not limited to, specialty physicians, hospitals, lab and x-ray, ancillary service providers, and home health; that are available through fee-for-service Medicaid providers.

The CCN shall assist the member in determining the need for services outside the CCN network and refer the member to the appropriate service provider.

The referral system must include processes to ensure monitoring and documentation of specialty health care services (e.g., medications prescribed, treatment received, recommendations for care), and follow up are included in the PCPs member medical record.

7.1.1.1 The CCN shall submit referral system policies and procedures to DHH for review and approval within thirty (30) days from the date the Contract is signed by the CCN, annually thereafter, and prior to any revisions. Referral policies and procedures shall describe referral systems and guidelines and, at a minimum, include the following:

- When a referral from the member's PCP is and is not required (See § 7.1.2.17.3 *Exceptions to Service Authorization and/or Referral Requirements*);
- Process for member referral to an Medicaid provider who has the appropriate training or expertise to meet the particular health needs of the member;
- Process for providing a standing referral when a member with a condition requires on-going care from a specialist;
- Process for referral to specialty care for a member with a life-threatening condition or disease who requires specialized medical care over a prolonged period of time;
- Process for member referral for case management;

- Process for member referral for chronic care management;

- Prohibit providers from making referrals for designated health services to health care entities with which the provider or a member of the provider's family has a financial relationship.

- Processes to ensure monitoring and documentation of specialty health care services and follow up are included in the PCP's member medical record.

  - There must be written evidence of the communication of the patient results/information to the referring physician by the specialty health care provider or continued communication of patient information between the specialty health care provider and the primary care provider; and

- Process for referral of members for services that are outside of the core benefits and services which will continue to be provided by enrolled Medicaid providers.

- DHH strongly encourages the CCN to develop electronic, web-based referral processes and systems. In the event a referral is made via the telephone, the CCN shall ensure that referral data, including the final decision, is maintained in a data file that can be accessed electronically by the CCN, the provider and DHH.

7.1.2. Utilization Management

The CCN shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review including service authorization and medical necessity review and are in accordance with the requirements set forth in this section and this RFP. The CCN shall submit UM policies and procedures to DHH within thirty (30) days from the date the Contract is signed by the

CCN for written approval, and annually and subsequent to any revisions.

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

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

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

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

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

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

7.1.2.2.2. UM Program medical management criteria and practice guidelines shall be disseminated to all affected providers, members and potential members upon request.

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

7.1.2.2.4. The CCN shall use the medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37,

Number 1) for medical necessity determinations.

7.1.2.2.5. The CCN must identify the qualifications of staff who will determine medical necessity.

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

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

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

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

7.1.2.2.8. The CCN shall provide a mechanism to reduce inappropriate and duplicative

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

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

7.1.2.2.10. The CCN shall disseminate Utilization Management practice guidelines to all affected providers, members, and potential members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.

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

7.1.2.2.12. The CCN shall meet the requirement outlined in 42 CFR §456.111 and 456.211. The CCN Utilization Review plan must provide that each enrollee's record includes information needed for the UR committee to perform UR required under this section. This information must include, at least, the following:

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

7.1.2.3. Utilization Management Committee

7.1.2.3.1. The UM program shall include a Utilization Management (UM) Committee that integrates with other

functional units of the CCN as appropriate and supports the QAPI Program (refer to the Quality Management subsection for details regarding the QAPI Program).

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

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

- Monitoring over- and under-utilization;
- Review of outliers, and
- Medical Record Reviews - reviews of member medical records shall be conducted to ensure that PCPs provide high quality health care that is documented according to established standards.

7.1.2.4. Medical Record Review Strategy

The CCN shall maintain a written strategy for conducting medical record reviews, reporting results and the corrective action process. The strategy shall be provided within thirty (30) days from the date the Contract is signed by the CCN and annually thereafter. The strategy shall include, at a minimum, the following:

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

The standards, which shall include all medical record documentation requirements addressed in the Contract, shall be distributed to all providers.

The CCN shall conduct reviews at all PCP sites with fifty (50) or more linked members and practice sites which include both individual offices and large group facilities. The CCN shall review each site at least one (1) time during each two (2) year period.

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

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

7.1.2.5. Reporting Requirements

The CCN shall submit utilization management reports as specified by DHH. DHH reserves the right to request additional reports as deemed by DHH. DHH will notify the CCN of additional required reports no less than 30 days prior to due date of those reports.

7.1.2.6. Service Authorization

Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post authorization.

The CCN shall provide service authorization **only** for those medically necessary services that require authorization under the Medicaid FFS system, with the exception of physician services as specified in § 7.1.5.1.1.

The CCN may only provider service authorization for abortions in the following situations in accordance with federal and state regulations:

- If the pregnancy is the result of an act of rape or incest; or

- In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician place the woman in danger of death unless an abortion is performed.

No other abortions, regardless of funding, can be provided as a benefit under the CCN Program.

The CCN UM Program policies and procedures shall include service authorization policies and procedures in accordance with state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following:

- Written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization member's request is for the provision of a service if a provider refuses a service or does not request a service in a timely manner;

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

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

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

grievance procedures consistent with 42 CFR §431.201;

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

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

7.1.2.6.1. Timing of Service Authorization Decisions

7.1.2.6.1.1. Standard Service Authorization

In regard to standard authorization decisions, the CCN shall provide notice as expeditiously as the enrollee's health condition requires and within

The CCN shall make eighty percent (80%) of initial standard service authorization within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard

service authorizations shall be made no later than fourteen (14) calendar days following receipt of the request for service unless an extension is requested. An extension may be granted for an additional fourteen (14) calendar days if:

- The member, or the provider, requests extension; or
- The CCN justifies (to DHH upon request) a need for additional information and how the extension is in the member's best interest.
- The CCN shall make concurrent review service authorizations within one (1) business day of obtaining the appropriate medical information that may be required.

7.1.2.6.1.2. Expedited Authorization Decisions

For cases in which a provider indicates, or the CCN determines, that following the standard timeframe could seriously

jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CCN must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires but no later than seventy-two (72) hours after receipt of the request for service.

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

7.1.2.6.1.3. Post Authorization

Decisions for authorization involving health care services that have been delivered shall be made within thirty (30) calendar days of receipt of the necessary information.

7.1.2.6.2. Notice of Action

The CCN shall notify the member, in writing using language that is easily understood, of decisions to deny a

service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in §*12 – Grievance, Appeal and State Fair Hearing* in this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.404(a) and (c) and 42 CFR §438.210(b)(c)(d) and *§12.6 – Notice of Action* in this RFP.

7.1.2.6.2.1. Approval

For service authorization approval for a non-emergency admission, procedure or service, the CCN shall notify the provider of as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.

For service authorization approval for extended stay or additional services, the CCN shall notify the provider rendering the service, whether a healthcare professional or facility or both, and the member receiving the service within one (1) business

day of the service authorization approval.

7.1.2.6.2.2. Adverse Determination

The CCN shall notify the member, in writing using language that is easily understood, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in Section § 12 of this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.404(a) and (c) and 42 CFR §438.210(b)(c)(d) and Section § 11 of this RFP for member written materials.

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

7.1.2.6.3. Exceptions to Service Authorizations and/or Referrals Requirements

7.1.2.6.3.1. The CCN shall not require:

- Service authorization for emergency services or post-stabilization

services as described in this Section whether provided by an in-network or out-of-network provider;

- Hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries;

- Service authorization or referral for EPSDT screening services;

- Service authorization for family planning services;

- Service authorization for for general eye care and vision services;

- A PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the CCN for routine and preventive women's healthcare services and prenatal care;

- A PCP referral for access to specialized behavioral health services;

- Service authorization for the continuation of medically necessary

State Plan services of a new member transitioning into the CCN, regardless of whether such services are provided by an in-network or out-of-network provider, however, the CCN may require prior authorization of services beyond thirty (30) calendar days. The CCN is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider.

7.1.2.6.3.2. The CCN may request to be notified by the provider, but shall not deny claims for payment based solely on lack of notification, for the following:

- Inpatient emergency admissions within forty-eight (48) hours of admission;
- Obstetrical care (at first visit); and
- Obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery and ninety-six (96) hours after caesarean section.

7.1.3 Medical History Information

The CCN is responsible for eliciting pertinent medical record information from the treating health care provider(s), as needed and/or as requested by DHH, for purposes of making medical necessity determinations. The CCN shall take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe.

7.1.4 PCP Utilization and Quality Profiling

7.1.4.1 The CCN shall profile its PCPs and analyze utilization data to identify PCP Utilization and/or quality of care issues. The CCN shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.

7.1.4.2 The CCN shall submit individual PCP profile reports to DHH quarterly. CCN PCP profiling activities shall include, but are not limited to, the following:

- Specialist referrals – The CCN shall maintain a procedure to identify and evaluate member specialty provider referral utilization by its PCP panel;
- Emergency department utilization – The CCN shall maintain a procedure to identify and evaluate member emergency department referral utilization by its PCP panel;
- Hospital admits, lab services, medications, and radiology services – The CCN shall maintain a procedure to identify and evaluate member's utilization; and
- Individual PCP clinical quality performance measures as indicated in Appendix H.

7.1.4.3 PCP Utilization & Quality Profile Reporting Requirements

The CCN shall submit profile reports quarterly with an Annual Summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than sixty (60) days prior to due date of those reports.

7.1.5 Care Coordination, Continuity of Care, and Care Transition

The CCN shall develop and maintain effective coordination, continuity of care, and care transition activities which ensure a continuum of care approach to providing health care services to CCN members. The CCN shall establish a process to coordinate the delivery of primary care services with other services that are reimbursed fee-for-service by DHH.

The CCN shall ensure member-appropriate PCP choice within the CCN and interaction with providers outside the CCN. Continuity of care activities shall ensure that the appropriate personnel, including the PCP, are kept informed of the member's treatment needs, changes, progress or problems. Continuity of care activities shall provide processes by which CCN members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The CCN shall ensure that service delivery is properly monitored to identify and overcome barriers to primary and preventive care that a CCN member may encounter.

7.1.5.1 Coordination of Medicaid State Plan Services

The CCN shall be required to provide service authorization, refer, coordinate, and/or provide assistance in scheduling medically necessary services consistent with the standards as defined in Louisiana State Medicaid Plan regarding service limits and service authorization requirements with the exception of physician visits (Materials can be found in the Procurement Library (see §20.8 of this RFP for Location). The CCN shall have policies and processes to authorize physician visits in excess of the 12 visit limit consistent with adult prior authoritarian requirements currently in Medicaid FFS. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

services authorizations are not subject to this 12 service limit.

Policy transmittals, State Plan amendments, regulations, provider bulletins, provider manuals, and fee schedules, issued by DHH are the final authority regarding services, and can be found in the Medicaid Procurement Library (See §20.8 of the RFP for location). The CCN shall be responsible to coordinate the following Louisiana Medicaid State Plan services:

- Inpatient Hospital Services
- Outpatient Services
- Ancillary Medical Services
- EPSDT/Well Child Visits
- Emergency Medical Services
- Communicable Disease Services
- Emergency Medical Transportation
- Home Health Services
- Family Planning Services as specified in 42 CFR §431.51(b)(2)
- Basic Behavioral Health Services
- School-Based Health Clinic Services
- Physician Services
- Maternity Services
- Organ Transplant and Related Services
- Chiropractic Services
- Rehabilitation Therapy Services (physical, occupational, and speech therapies)
- Federally Qualified Health Clinics (FQHC)/Rural Health Clinics (RHC) Services

7.1.5.1.1 The CCN will not be responsible to pre-process or provide service authorization, but shall provide any required referrals and coordination, for the following services:

- Services provided through DHH's Early Step Services (IDEA Part C Program Services)
- Dental Services

- Personal Care Services (EPSDT and LT-PCS)
- Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Services
- Home & Community-Based Waiver Services
- Hospice Services
- Non-Emergency Transportation
- School-based Individualized Education Plan (IEP) Services provided by a school district and billed through the intermediate school district
- Nursing Facility Services
- Pharmacy (Prescription Drugs)
- Specialized Behavioral Health Services
- Targeted Case Management
- Durable Medical Equipment and certain supplies
- Prosthetics and orthotics; and

7.1.5.1.2 The CCN shall implement DHH approved care coordination and continuity of care policies and procedures that meet or exceed the following requirements:

- Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs;

- Coordinate care between PCPs and specialists;

- Coordinate care for out-of-network services, including specialty care services;

- Coordinate CCN provided services with services the member may receive from other health care providers;

- Share with other health care entities serving the member with special health

care needs the results and identification and assessment of that member's needs to prevent duplication of those activities;

- Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 subparts A and E, to the extent applicable and other applicable state or federal laws;

- Maintain and operate a formalized hospital and/or institutional discharge planning program;

- Coordinate with hospital and/or institutional discharge planning that includes post-discharge care as appropriate;

- Identify members using emergency department services inappropriately and assist in scheduling follow-up care with PCP and/or appropriate specialists;

- Document authorized referrals in its utilization management system; and

- Provide active assistance to members receiving treatment for chronic and acute medical conditions or behavioral health conditions to transition to another provider when their current provider has terminated participation with the CCN. The CCN shall provide continuation of such services for up to ninety (90) calendar days or until the member is reasonably transferred without interruption of care, whichever is less.

7.1.5.1.3 Continuity of Care for Pregnant Women

- In the event a Medicaid/CHIP eligible entering the CCN is receiving medically necessary covered services in addition to, or other than, prenatal services (see below for new enrollees receiving only prenatal services) the day before CCN enrollment, the CCN shall provide continuation/coordination of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The CCN may require prior authorization for continuation of the services beyond thirty (30) calendar days, however the CCN is prohibited from denying authorization solely on the basis that the provider is non-contract provider.

- In the event a Medicaid/CHIP eligible entering the CCN is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services, from a Medicaid enrolled provider, the day before CCN enrollment, the CCN shall be responsible for the coordination of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of prior approval.

- In the event a Medicaid/CHIP eligible entering the CCN is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment from a Medicaid enrolled provider, the CCN shall be responsible for coordinating continued access to the

prenatal care provider through the postpartum period.

7.1.5.1.4 Continuity for Behavioral Health Care

- The PCP shall provide basic behavioral health services (as described in *this section)* and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.

- In order to ensure continuity and coordination of care for members who needs specialized behavioral health services or who may require inpatient/outpatient behavioral health services, the CCN shall be responsible for referring to the fee-for-service system or other managed care arrangement responsible for specialized behavioral health services (as applicable) for services.

- In any instance when the member presents to the network provider, including calling the CCN's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the CCN shall instruct the member to seek help from the nearest emergency medical provider. The CCN shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.

- The CCN shall include documentation in the member's medical record that attempts are made to engage the member's cooperation and permission to coordinate the member's over-all care

plan with the member's behavioral health provider.

- The network shall provide procedures and criteria for making referrals and coordinating care with behavioral health providers and agencies that will promote continuity, as well as, cost-effectiveness of care.

- These procedures must address members with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple provides, facilities and agencies and require complex coordination of benefits and services.

- The CCN shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures.

7.1.5.1.5 Continuity of Services for Individuals with Special Health Care Needs

During the initial implementation of the CCN Program in the event a Medicaid/CHIP eligible entering the CCN is receiving medically necessary covered services, the day before CCN enrollment, the CCN shall provide continuation/coordination of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The CCN may require prior authorization for continuation of the services beyond thirty (30) calendar days; however the CCN is prohibited from denying authorization solely on the basis that the provider is non-contract provider.

7.1.5.2 Care Transition

- The CCN shall provide active assistance to members when transitioning to another provider (CCN or Medicaid FFS programs).
- The receiving CCN shall be responsible for the provision of medically necessary services covered under the Contract that are required for the member during the transition period. The transition period shall not exceed thirty (30) calendar days from the effective date of the member's enrollment in the receiving CCN. During this transition period, the receiving CCN shall be responsible for notification to the new PCP of member's selection, initiation of the request of transfer for the member's medical files, arrangement of medically necessary services (if applicable) and all other requirements for new members.

- If a member is to be transferred between CCNs but is hospitalized at the time, the transfer shall be effective for the date of enrollment into the receiving CCN. However, the relinquishing CCN shall notify the receiving CCN of the member's hospitalization status within five (5) business days.

- Upon notification of the member's transfer, the receiving CCN shall request copies of the member's medical record, unless the member has arranged for the transfer. The previous provider shall transfer a copy of the member's complete medical record and allow the receiving CCN access (immediately upon request) to all medical information necessary for the care of that member. Transfer of records shall not interfere or cause delay in the provision of services to the member. The cost of reproducing and forwarding medical records to the receiving CCN shall be the responsibility of the relinquishing CCN. A copy of the member's medical record and

supporting documentation shall be forwarded by the relinquishing CCN's PCP within ten (10) business days of the receiving CCN's PCP's request.

- Appropriate medical records and case management files of the transitioning member shall also be transmitted. The cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing Contractor.

- At the point of initial CCN implementation in the GSA, the CCN shall ensure a smooth transition for members by not discontinuing a member's existing Louisiana Medicaid service plan for 30 days after the member transition unless mutually agreed to by the member or responsible party. Members who transition from one CCN to another are considered newly enrolled with the receiving CCN.

- The CCN shall designate a person with appropriate training and experience to act as the Transition Coordinator. This staff person shall interact closely with the DHH Medicaid Coordinated Care Section staff and staff from other CCNs to ensure a safe and orderly transition.

- When relinquishing members, the CCN is responsible for timely notification to the receiving CCN regarding pertinent information related to any special needs of transitioning members. The CCN, when receiving a transitioning member with special needs, is responsible to coordinate care with the relinquishing Contractor so services are not interrupted, and for providing the new member with CCN and service information, emergency numbers and instructions on how to obtain services.

7.1.6 Case Management

The CCN shall develop and implement a case management program through a process which provides that appropriate and cost-effective medical services, medically-related services, other services, and behavioral health services are identified, planned, obtained and monitored for identified members who are high risk or have unique, chronic, or complex needs. The process shall integrate the member's and case manager's review of the member's strengths and needs resulting in a mutually agreed upon appropriate and cost-effective service plan that meets the medical, functional, and behavioral health needs of the member. The case manager should assist/facilitate the discharge planning process when assistance is needed to ensure patients receive care deemed medically necessary by the treating physician. The CCN shall submit case management program policies and procedures to DHH for approval within thirty (30) days of the date the Contract is signed by the CCN and annually thereafter.

7.1.6.1 Case Management Functions

7.1.6.1.1 Case management functions shall include, but are not limited to:

- Early identification of members who have or may have special needs;
- Assessment of a member's risk factors;
- Education regarding Patient-Centered Medical Home and referral to a Medical Home when appropriate;
- Development of an individualized treatment care plan which must be:
  - Developed by the member's PCP, with enrollee participation, and in consultation with any specialists caring for the member,
  - Approved by the CCN in a timely manner if required by the CCN; and

- In compliance with applicable QA and UM standards

- Referrals and assistance to ensure timely access to providers;

- Care coordination that actively links the member to providers, medical services, residential, social, community and other support services where needed;

- Monitoring;

- Continuity of care; and

- Follow-up and documentation.

7.1.6.1.2 Case Management Policies and Procedures

The CCN shall submit Case Management Program policies and procedures to DHH for approval within thirty (30) days from date the Contract is signed by the CCN, annually thereafter, and subsequent to any revisions. Case Management policies and procedures shall, at a minimum, include the following elements:

- A process to offer voluntary participation in the Case Management Program to eligible members;

- Identification criteria, process, and triggers for referral and admission into the Case Management Program;

- The provision of an individual needs assessment and diagnostic assessment; the development of an individual treatment care plan, as necessary, based on the needs assessment; the establishment of short and long term treatment objectives; the monitoring of outcomes; and a process to

ensure that treatment care plans are revised as necessary. These procedures shall be designed to accommodate the specific cultural and linguistic needs of the CCN's members; Procedures must describe collaboration processes with member's treatment providers;

- A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;

- Procedures and criteria for making referrals to specialists and subspecialists and follow-up of those referrals;

- Procedures and criteria for maintaining treatment care plans and referral services when the member changes PCPs; and

- Coordinate Case Management activities for members also receiving services through the CCN's Chronic Care Management Program.

7.1.6.1.3 Identifying Individuals with Special Health Care Needs

The CCN shall implement mechanisms to assess each Medicaid member identified or has self identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring to the CCN or PCP. The assessment mechanisms must use appropriate health care professionals. The CCN shall have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

The CCN shall utilize historical claims data (if available) to identify members who meet CCN, DHH approved, guidelines for meeting SHCN

criteria. The CCN must identify members with potential SHCN within ninety (90) days of receiving the member's historical claims data (if available).

CCN PCPs shall identify members who meet SHCN criteria to the CCN. The PCP can identify members as having special needs at any time the member presents with those needs. The CCN must assess those members within ninety (90) days of identification. The assessment must be done by appropriate healthcare professionals.

Assessments that determine a course of treatment or regular care monitoring is appropriate shall result in a referral for Case Management. However, during the phase-in implementation of the Coordinated Care Program, DHH will extend this requirement to one hundred and eighty (180) days from the enrollment effective date.

The CCN must have a mechanism in place to allow enrollees with special health care needs to directly access a specialist(s) (for example, through a standing referral) as appropriate for the member's condition and identified needs, consistent with 42 CFR §438.208.

7.1.6.1.4 Case Management Reporting Requirements

The CCN shall submit case management reports quarterly with an annual summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than sixty (60) days prior to the due date of those reports. The case management reports shall include, at a minimum:

- Number of members identified with potential special healthcare needs utilizing historical claims data;
- Number of members with special healthcare needs identified by the member's PCP;
- Number of identified members with assessments;
- Number of members with assessments resulting in a referral for Case Management; and
- Number of treatment care plans completed.

7.1.7 Chronic Care Management Program (CCMP)

The CCN shall implement a Chronic Care Management Program (CCMP) as identified in this RFP for members with chronic conditions. The Chronic Care Management Program shall:

- Emphasize prevention of exacerbation and complication of chronic diseases utilizing evidence based clinical practice guidelines and patient empowerment and activation strategies;
- Encourage the evaluation of clinical, humanistic and economic outcomes;
- Address co-morbidities through a whole-person approach; and
- Promote chronic care management strategies, such as: referral processes; after hours protocols, and targeted management to focus on those in greatest need.

7.1.7.1 The CCN shall provide a Chronic Care Management Program (CCMP) for members diagnosed with the following chronic conditions:

- Asthma;
- Diabetes; and
- Congestive heart failure.

The CCN shall also include one of the following chronic conditions in the CCMP for its members: hypertension as a precursor to coronary artery disease and stroke; sickle cell anemia, chronic obstructive pulmonary disease (COPD), low back pain and chronic pain. Additional chronic conditions may be added at the CCN's discretion. The CCN shall include additional discretionary chronic conditions in CCMP reports, as delineated for required chronic conditions in the CCMP, to DHH.

7.1.7.1.1 CCMP Policies and Procedures

The CCN shall submit Chronic Care Management Program policies and procedures to DHH for approval within thirty (30) days after the Contract is signed by the CCN, annually and subsequent to any revisions. The CCN shall develop and implement policies and procedures that:

- Include the definition of the target population;
- Include member identification strategies;
- Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;
- Include guidelines for treatment plan development, as described in NCQA Disease Management program content, that provide the outline for all program activities and interventions;
- Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions;

- Include methods for informing and educating members and providers;

- Emphasize exacerbation and complication prevention utilizing evidence- based clinical practice guidelines and patient empowerment and activation strategies;

- Conduct and report the evaluation of clinical, humanistic and economic outcomes;

- Address co-morbidities through a whole-person approach;

- Coordinate CCMP activities for members also identified in the Case Management Program; and

- Include Program Evaluation requirements.

7.1.7.1.2 Predictive Modeling

The CCN shall use predictive modeling methodology to identify and stratify members eligible for the CCMP.

The CCN shall submit specifications of its Predictive Modeling methodology, including its risk scoring, stratum, and healthcare guidelines to DHH for approval within thirty (30) days after the Contract is signed by the CCN, annually thereafter, and prior to any changes. These specifications shall include but are not limited to:

- A brief history of the tool's development and historical and current uses;

- Medicaid data elements to be used for predictors and dependent measure(s);

- Assessments of data reliability and model validity;

- A description of the rules and strategy to achieve projected clinical outcomes and how clinical outcomes shall be measured; and

- A description of how the model has been optimized on these type interventions and the constraints on intervention to the Medicaid program and population.

7.1.7.1.3 Chronic Care Management Program Reporting Requirements

The CCN shall submit Chronic Care Management reports quarterly to DHH. DHH reserves the right to request additional reports as deemed necessary.

DHH will notify the CCN of additional required reports no less than sixty (60) days prior to due date of those reports.

- The CCMP reports shall contain at a minimum:

  - Total number of members;
  - Number of members in each stratification level for each chronic condition; and
  - Number of members who were disenrolled from the program and an explanation as to why they were disenrolled.

The CCN shall submit an annual CCMP evaluation.

7.1.8 <u>Quality Management</u>

The CCN shall have an ongoing Quality Assessment and Performance Improvement (QAPI) Program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services and promotes improved

patient outcomes through monitoring and evaluation activities. Improvement strategies include, but are not limited to, performance improvement projects, medical record audits, performance measures, and surveys.

The CCN shall have mechanisms to 1) detect underutilization and overutilization of services and 2) assess the quality and appropriateness of care furnished to enrollees with special health care needs.

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

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

The CCN shall submit a QAPI Quality Assessment Work plan within thirty (30) days from the date the Contract is signed and annually thereafter, for DHH review and approval.

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

The CCN shall have a process in place to evaluate the impact and effectiveness of its QAPI program. DHH must approve any material change to this plan prior to implementation of the revisions.

7.1.8.1 QAPI Committee

7.1.8.1.1 The CCN shall form a QAPI Committee.

7.1.8.1.2 The CCN Medical Director must serve as either the chairman or co-chairman.

7.1.8.1.3 Appropriate CCN staff representing the various departments of the organization will have membership on the committee.

7.1.8.1.4 The CCN is encouraged to include a member advocate representative on the QAPI Committee.

7.1.8.1.5 The QAPI Committee shall meet on a quarterly basis. Its responsibilities shall include:

- Direct and review quality improvement (QI) activities;
- Assure that QAPI activities take place throughout the CCN;
- Review and suggest new and/or improved QI activities;
- Direct task forces/committees to review areas of concern in the provision of healthcare services to members;
- Designate evaluation and study design procedures;
- Conduct individual PCP and practice quality performance measure profiling;
- Report findings to appropriate executive authority, staff, and departments within the CCN;
- Direct and analyze periodic reviews of members' service utilization patterns; and
- Maintain minutes of all committee and sub-committee meetings. Submit meeting minutes to DHH within 5 working days of the meetings.

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

- Ensure that a QAPI committee designee attends DHH's quality meetings.

7.1.8.2 QAPI Plan

The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic division provided by the governing body. The QAPI plan shall be submitted to DHH for written approval

within thirty (30) date the Contract is signed, annually thereafter, and prior to revisions. The QAPI plan shall:

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

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

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

7.1.8.2.1 QAPI Reporting Requirements

The CCN shall submit QAPI reports annually to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than thirty (30) days prior to due date of those reports. The QAPI reports shall contain at a minimum:

- Quality improvement (QI) activities;
- Recommended new and/or improved QI activities; and
- Evaluation of the impact and effectiveness of the QAPI program.

7.1.8.3 The CCN shall participate in the Department's quality committee.

7.1.8.4 The CCN will agree to an External Quality Review, review of the Quality Assessment Committee meeting minutes, and annual medical audits to ensure that CCN providers provide quality and accessible health care to CCN members, in accordance with standards contained in this RFP and under the terms of this RFP. Such audits shall allow DHH or its duly authorized representative to review individual medical records, identify and collect management data, including but not limited to surveys and other information concerning the use of services and the reasons for member disenrollment.

7.1.8.5 It is agreed that the standards by which the CCN will be surveyed and evaluated will be at the sole discretion and approval of DHH. If deficiencies are identified, the CCN must formulate a Corrective Action Plan (CAP) incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. The CAP is subject to DHH prior approval.

7.1.8.6 In the event the CCN fails to complete the actions required by the CAP, the CCN agrees that DHH may assess the monetary penalties specified in this RFP. The CCN further agrees that any monetary penalties assessed by DHH will be due and payable to DHH immediately upon notice. If payment is not made by the due date, said monetary penalties may be withheld from future enhanced primary care case

management fee payments by DHH without further notice.

7.1.8.7 The CCN is required to conduct performance improvement projects as specified in this RFP.

7.1.9 Performance Measures

7.1.9.1 The CCN shall report clinical and administrative performance measure (PM) data, as specified by DHH and in accordance with the specifications of the CCN Quality Companion Guide.

7.1.9.2 The CCN is required to report on PMs listed in Appendix H which include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) measures, Agency for Healthcare Research and Quality Review (AHRQ) measures, Consume Assessment of Healthcare Providers and Systems (CAHPS) measures, and/or other measures as determined by DHH.

7.1.9.3 The CCN shall have processes in place to monitor and self-report all performance measures.

7.1.9.4 Clinical PM outcomes shall be submitted to DHH annually and upon DHH request.

7.1.9.5 Administrative PMs shall be submitted to DHH semi-annually and upon DHH request.

7.1.9.6 The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.

7.1.10 Early Warning System Performance Measures

The CCN shall collect and report monthly on the Early Warning System Performance Measure outcomes, as specified by DHH in this RFP (Appendix H), in order to monitor and evaluate the successful implementation of the CCN program.

During a CCN's first two years of operations, distribution of any savings will be contingent upon the CCN meeting the established "Early Warning System" performance measures and compliance under this Contract. After the second year of operations, distribution of any savings will be contingent upon the CCN meeting established performance measures and compliance with this Contract.

7.1.11 Incentive Based Measures

7.1.11.1 Incentive Based (IB) measures are Level I measures that may affect savings payments and can be identified in Appendix H with "$".

7.1.11.2 A maximum of 100% eligible (20% for each of the 5 Incentive Based Performance Measures) savings payout will be contingent upon the CCN's Performance Measure outcomes for CYE 12/31/2013 or otherwise specified by DHH. All Incentive Based and Level I performance measures that fall below performance standards will require a corrective action plan (CAP) (See Appendix H).

7.1.11.3 DHH expressly reserves the right to modify existing performance IB measures. Any changes in the Incentive Based performance measures will require an amendment to the Contract and DHH will provide sixty (60) days notice of such change.

7.1.12 Reporting Measures

7.1.12.1 All Administrative, Level I and Level II PMs are reporting measures.

7.1.12.2 Administrative measure reporting is required semiannually and upon DHH request.

7.1.12.3 Prevention Quality Indicator measures within Level I shall be reported quarterly and upon DHH request beginning in 2013 utilizing CY 2012 data for Contracts that begin January 1, 2012.

7.1.12.4 Prevention Quality Indicator measures within Level I shall be reported quarterly and upon DHH request beginning in 2014 utilizing CY 2013 data for Contracts that begin after January 1, 2012.

7.1.12.5 Level I and Level II measure reporting is required annually, and upon DHH request, beginning in 2013 utilizing CY 2012 data for Contracts that begin January 1, 2012.

7.1.12.6 Level I and Level II measure reporting is required annually, and upon DHH request, beginning in 2014 utilizing CY 2012 data for Contracts that begin after January 1, 2012.

7.1.12.7 DHH may add or remove PM reporting requirements with a sixty (60) day advance notice.

7.1.13 <u>Performance Measure Goals</u>

7.1.13.1 The Department will establish benchmarks for Incentive Based and Level I Performance measures utilizing statewide data of the Medicaid Fee for Service Population for CY 2011 with the expectation that performance improves by a certain percentage.

7.1.13.2 Statewide goals will be set for 2015 Level II Performance Measures utilizing an average of all CCNs' outcomes received in 2014 for the 2013 measurement year.

7.1.14 <u>Performance Measure Reporting</u>

7.1.14.1 The CCN shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.

7.1.14.2 The tools and reports will be flexible and adaptable to changes in the quality measurements required by DHH.

7.1.14.3 The CCN shall have processes in place to monitor and self-report performance measures as specified in §16,

Reporting Measures using DHH specified requirements and format. The CCN shall provide individual PCP clinical quality profile reports as indicated specified by DHH.

7.1.15 Performance Measure Monitoring

7.1.15.1 DHH will monitor the CCN's performance using Benchmark Performance and Improvement Performance data.

7.1.15.2 During the Contract, DHH or its designee will actively participate with the CCN to review the results of performance measures.

7.1.15.3 The CCN shall comply with External Quality Review, review of the Quality Assessment Committee meeting minutes and annual medical audits to ensure that it provides quality and accessible health care to CCN members, in accordance with standards contained in the Contract. Such audits shall allow DHH or its duly authorized representative to review individual medical records, identify and collect management data, including but not limited to, surveys and other information concerning the use of services and the reasons for member disenrollment.

7.1.15.4 The standards by which the CCN will be surveyed and evaluated will be at the sole discretion and approval of DHH. If deficiencies are identified, the CCN must formulate a Corrective Action Plan (CAP) incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. The CAP is subject to approval by DHH. DHH will monitor the CCN's progress in correcting the deficiencies.

7.1.16 Corrective Action Plan

A corrective action plan (CAP) will be required for performance measures that do not reach the Department's performance benchmark.

7.1.16.1 The CCN shall submit a CAP, within thirty (30) calendar days of the date of notification or as specified by DHH, for the violation or non-compliance specified by DHH.

7.1.16.2 Within thirty (30) calendar days of receiving the CAP, DHH will either approve or disapprove the CAP. If disapproved, the CCN shall resubmit, within fourteen (14) calendar days, a new CAP that addresses the concerns identified by DHH.

7.1.16.3 Upon approval of the CAP, whether the initial CAP or the revised CAP, the CCN shall implement the CAP within the time frames specified by DHH.

7.1.16.4 DHH may impose monetary penalties, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.

7.1.17 <u>Performance Improvement Projects</u>

7.1.17.1 The CCN shall establish and implement an ongoing program of Performance Improvement Projects (PIP) that focus on clinical and non-clinical performance measures as specified in 42 CFR §438.240.

7.1.17.2 The CCN shall perform a minimum of two (2) DHH approved PIPs in the first Contract year. The DHH required PIP during the first Contract year is listed in Section 1 of Appendix V - Performance Improvement Projects. The CCN shall choose the second PIP from Section 2 of Appendix V. DHH may require an additional PIP each successive year to reach a maximum of four (4) PIPs.

7.1.17.3 Performance Improvement Projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time, with favorable effects on health outcomes and enrollee satisfaction. Each PIP must involve the following:

a. Measurement of performance using objective quality indicators;

b. Implementation of system interventions to achieve improvement in quality;

c. Evaluation of the effectiveness of the interventions; and

d. Planning and initiation of activities for increasing or sustaining improvement.

7.1.17.4 Within three (3) months of the execution of the Contract and at the beginning of each Contract year thereafter, the CCN shall submit, in writing, a general and a detailed description of each PIP to DHH for approval. The detailed PIP description shall include:

a. An overview explaining how and why the project was selected, as well as its relevance to the CCN members and providers;

b. The study question;

c. The study population;

d. The quantifiable measures to be used, including a goal or benchmark;

e. Baseline methodology;

f. Data sources;

g. Data collection methodology and plan;

h. Data collection cycle;

i. Data analysis cycle and plan;

j. Results with quantifiable measures;

k. Analysis with time period and the measures covered;

l. Analysis and identification of opportunities for improvement; and

m. An explanation of all interventions to be taken.

7.1.17.5 PIPs used to measure performance improvement shall include diagrams (e.g. algorithms and /or flow charts) for monitoring and shall:

a. Target specific conditions and specific health service delivery issues for focused system-wide and individual practitioner monitoring and evaluation;

b. Use clinical care standards and/or practice guidelines to objectively evaluate the care the CCN delivers or fails to deliver for the targeted clinical conditions;

c. Use appropriate quality indicators derived from the clinical care standards and/or practice guidelines to screen and monitor care and services delivered;

d. Implement system interventions to achieve improvement in quality;

e. Evaluate the effectiveness of the interventions;

f. Provide sufficient information to plan and initiate activities for increasing or sustaining improvement;

g. Monitor the quality and appropriateness of care furnished to enrollees with special health care needs;

h. Reflect the population served in terms of age groups, disease categories, and special risk status,

i. Ensure that appropriate health professionals analyze data;

j. Ensure that multi-disciplinary teams will address system issues;

k. Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal benchmark;

l. Validate the design to assure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis, and

m. Maintain a system for tracking issues over time to ensure that actions for improvement are effective.

7.1.17.6 DHH, in consultation with CMS and other stakeholders, may require specific performance measures and topics for performance improvement projects. The CCN shall report the status and results of each PIP as specified in the ***Quality Companion Guide***.

a. If CMS specifies Performance Improvement Projects, the CCN will participate and this will count toward the State-approved PIPs.

7.1.17.7 Each Performance Improvement Project shall be completed in a reasonable time period so as to generally allow information on the success of Performance Improvement Projects in the aggregate to produce new information on quality of care every year.

7.1.18 <u>PIP Reporting Requirements</u>

7.1.18.1 The CCN shall submit PIP outcomes annually to DHH.

7.1.18.2 Reporting specifications are detailed in the Quality Companion Guide.

7.1.18.3 DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than thirty (30) days prior to due date of those reports.

7.1.19 Member Advisory Council

The CCN shall establish a Member Advisory Council to promote collaborative effort to enhance the service delivery system in local communities while maintaining **member focus** and allow participation in providing input on policy and programs. The Council is to be chaired by the CCN's Administrator/CEO/COO or designee and will meet at least quarterly. Every effort shall be made to include a broad representation of both members/families /significant others, member advocacy groups and providers that reflect the population and community served. Members/families /significant others and member advocacy groups shall make up at least fifty per cent (50%) of the membership. The CCN shall provide an orientation and ongoing training for Council members so they have sufficient information and understanding to fulfill their responsibilities. The CCN shall develop and implement a Member Advisory Council plan that outlines the schedule of meetings and the draft goals for the council that includes, but is not limited to, member's perspectives to improve quality of care. This plan shall be submitted to DHH within thirty (30) days of signing the Contract and annually thereafter by December 15th. DHH shall be included in all correspondence to the Council, including agenda and Council minutes. Additionally, all agenda and Council minutes shall be posted to the CCN website.

A representative of the Member Advisory Council shall participate on the DHH CCN Member Advisory Committee.

7.1.20 Member Satisfaction Surveys

7.1.20.1 The CCN shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and utilize methodology to assess the quality and appropriateness of care to members.

7.1.20.2 The CCN shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys.

a. The CCN's vendor shall perform CAHPS Adult surveys, CAHPS Child surveys, and CAHPS Children with Chronic Conditions survey.

7.1.20.3 Survey results and a description of the survey process shall be reported to DHH separately for each required CAHPS survey.

7.1.20.4 The CAHPS survey results shall be reported separately for each CCN GSA. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the CCN at the time of the survey.

7.1.20.5 The surveys shall provide valid and reliable data for results in the specific CCN GSA.

7.1.20.6 Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.

7.1.20.7 The most current CAHPS Health Plan Survey (currently 4.0) for Medicaid Enrollees shall be used and include:

a. Getting Needed Care
b. Getting Care Quickly
c. How Well Doctors Communicate
d. Health Plan Customer Service
e. Global Ratings

7.1.20.8 Member Satisfaction Survey Reports are due one-hundred and twenty (120) days after the end of the plan year.

7.1.21 <u>Provider Satisfaction Surveys</u>

7.1.21.1 The CCN shall conduct an annual provider survey to assess satisfaction with provider enrollment, provider

communication, provider education, provider complaints, claims preprocessing, and utilization management processes, including medical reviews and support toward Patient Centered Medical Home implementation.

7.1.21.1.1 The Provider Satisfaction survey tool and methodology must be submitted to DHH for approval prior to administration.

7.1.21.2 The CCN shall submit an annual Provider Satisfaction Survey Report that summarizes the survey methods and findings and provides analysis of opportunities for improvement. Provider Satisfaction Survey Reports are due one-hundred and twenty (120) days after the end of the contract year.

7.1.22 <u>DHH Oversight of Quality</u>

DHH shall evaluate the CCN's QAPI, PMs, and PIPs at least one (1) time per year at dates to be determined by DHH, or as otherwise specified by the Contract.

If DHH determines that the CCN's quality performance is not acceptable, DHH will require the CCN to submit a corrective action plan (CAP) for each unacceptable performance measure. If the CCN fails to provide a CAP within the time specified, DHH will sanction the CCN in accordance with the provisions of sanctions set forth in the Contract, and may immediately terminate all new enrollment activities and automatic assignments.

Upon any indication that the CCN's quality performance is not acceptable, DHH may restrict the CCN's enrollment activities including, but not limited to, termination of automatic assignments.

When considering whether to impose a limitation on enrollment activities or automatic assignments, DHH may take into account the CCN's cumulative performance on all quality improvement activities.

The CCN shall cooperate with DHH, the independent evaluation contractor (External Quality Review Organization), and any other Department designees during monitoring.

7.1.22.1 External Independent Review

7.1.22.1.1 The CCN shall provide all information requested by the External Quality Review Organization (EQRO) and/or DHH including, but not limited to, quality outcomes concerning timeliness of, and member access to, core benefits and services.

7.1.22.1.2 The CCN shall cooperate with the EQRO during the review (including medical record review, which will be done at least one (1) time per year.

7.1.22.1.3 If the EQRO indicates that the quality of care is not within acceptable limits set forth in the Contract, DHH may sanction the CCN in accordance with the provisions of §18 and may immediately terminate all enrollment activities and automatic assignment until the CCN attains a satisfactory level of quality of care as determined by the EQRO.

7.1.22.1.4 A description of the performance improvement goals, objectives, and activities developed and implemented in response to the EQR findings will be included in the Contractor's QAPI program. DHH may also require separate submission of an improvement plan specific to the findings of the EQR.

7.2. Behavioral Health Services

The CCN shall strongly support the integration of both physical and behavioral health services through screening and strengthening prevention/early intervention at the PCP level of care. The PCP shall collaborate with behavioral health specialists, including but not limited to, psychiatrists, psychologists, licensed clinical social workers, or licensed professional counselors either in mental health clinics, mental health rehabilitation service providers (public or

private), and other specialty behavioral health providers, to ensure the provision of services to members as specified in the Medicaid State Plan.

For the purposes of this RFP, behavioral health services shall be divided into two levels:

7.2.1 Basic behavioral health services shall include, but not be limited to, screening, prevention, early intervention, medication management, and referral services as defined in the Medicaid State Plan; and

7.2.1.1 Specialized behavioral health services shall include, but not be limited to, services specifically defined in state plan and provided by psychiatrists, psychologists, and/or mental health rehabilitation providers to those members with a primary diagnosis of a mental and/or behavioral disorder.

7.2.1.2 Basic Behavioral Health Services

The CCN shall be responsible for ensuring the provision of basic behavioral health benefits and services to all members. The CCN PCPs shall utilize the screening tools and protocols approved by DHH.

7.2.2 The CCN shall be responsible for providing basic behavioral health benefits and services to all members. The CCN shall utilize the screening tools and protocols approved by DHH. Basic behavioral health services/benefits shall include, but may not be limited to:

- Screening, Prevention and Referral:

  - Screening, prevention, early intervention and referral services including screening services as defined in the EPSDT benefit (the EPSDT benefit guarantees coverage of "screening services" which must, at a minimum, include "a comprehensive health and developmental history – including assessment of both physical and mental health. Section 1905(r)(1)(B)(i) of the Social Security Act, 42 U.S.C. §1396d(r)(1)(B)(i));

  - Behavioral health services provided in the member's PCP or medical office as described under the "Basic Services" section above(e.g., DO, MD);

- Outpatient non-psychiatric hospital services, based on medical necessity; and

- Those behavioral health services for individuals whose need for such services is secondary to a primary medical condition in any given episode of care.

7.3. Emergency Services

The CCN shall insure that emergency and post-stabilization services are coordinated without the requirement of prior authorization of any kind; and shall advise all CCN members of the provisions governing the use of emergency services. The CCN shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

7.4. Family Planning Services

The CCN shall notify and give each member, including adolescents, the opportunity to use their own PCP or utilize any family planning service provider for family planning services without requiring a referral or authorization. Family planning services shall be available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments and traditional contraceptive devices. The CCN family planning services shall also include preconception care services for members to optimize member health entering pregnancy. The CCN shall agree to make available all family planning services to CCN members as specified in on the Louisiana Medicaid State Plan.

CCN members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the CCN's provider network without any restrictions as specified in 42 CFR §431.51(b)(2). The out-of-network Medicaid enrolled family planning services provider will submit the claim to the CCN and will be reimbursed no less than the Medicaid rate in effect on the date of services by DHH's FI. CCN members should be encouraged by the CCN to receive family planning services through the CCN's network of providers to ensure continuity and coordination of the member's total care.

7.5. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/ Well Child Visits

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) mandates **that all medically necessary services** listed in Section 1905(a) of the Social Security Act

be covered under Medicaid for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program provided for Medicaid eligible individuals under the age of 21. (CFR 42, Subpart B §441.50– Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] of Individuals under Age 21) The CCN is responsible to provide or authorize **all medically necessary services whether specified in the core benefits and services and Louisiana Medicaid State Plan or not**, except those services (carved out/excluded/ prohibited services) that have been identified in this RFP.

7.5.1 The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is a comprehensive and preventative child health program for individuals under the age of 21. The EPSDT statute and federal Medicaid regulations require that states cover all services within the scope of the federal Medicaid program, including services outside the Medicaid State Plan, if necessary to correct or ameliorate a known medical condition. 42 U.S.C. § 1396d(r)(5). The program consists of two mutually supportive, operational components: (1) assuring the availability and accessibility of required healthcare services; and (2) helping Medicaid members and their parents or guardians effectively use these resources. The intent of the EPSDT program is to direct attention to the importance of preventive health services and early detection and treatment of identified problems.

7.5.2 The CCN shall have written procedures for EPSDT services in compliance with 42 CFR §441.50, Subpart B-Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), as well as be in compliance with the Centers for Medicare and Medicaid Services (CMS) State Medicaid Manual, Part 5 – EPSDT for notification, tracking, and follow-up to ensure these services will be available to all eligible Medicaid CCN Program children and young adults. These articles outline the requirements for EPSDT, including assurance that: all EPSDT eligible members are notified of EPSDT available services; necessary screening, diagnostic, and treatment services are available and provided; and tracking or follow-up occurs to ensure all necessary services were provided to all of the CCN's eligible Medicaid children and young adults.

7.5.3 The CCN shall assure that all medically necessary diagnosis, treatment and screenings services are provided, either directly, through contracting, or by referral. The utilization of these services shall be reported as referenced in this RFP. The CCN's providers shall also report the required immunization data into the Louisiana

Immunization Information System (LINKS) administered by the DHH/Office of Public Health.

7.5.4 The CCN shall accurately report, via submission of claims to DHH, all EPSDT and well-child services, blood lead screenings, and access to preventive services as required for DHH to comply with federally mandated CMS 416 reporting requirements.

7.5.5 DHH shall use claims data submissions to determine the CCN's compliance with the state's established goals of:

7.5.5.1 Seventy-five (75) percent of eligible members under the age of twenty-one (21) are receiving EPSDT well child visits in accordance with the periodicity schedule for FFY 2012.

7.5.5.2 Seventy-eight (78) percent of eligible members under the age of twenty-one (21) are receiving EPSDT well child visits in accordance with the periodicity schedule for FFY 2013.

7.5.5.3 Eighty (80) percent of eligible members under the age of twenty-one (21) are receiving EPSDT well child visits in accordance with the periodicity schedule for FFY 2014.

7.6. Women's Health Services

The CCN shall assure direct access by female members to an OB/GYN within the provider's network (if the OB/GYN is the member's PCP) or a OB/GYN Medicaid provider for routine OB/GYN services regardless of whether the PCP (general practitioner, family practitioner or internist) provides such services. Routine gynecological care shall mean a minimum of two routine annual visits, provided that the second visit shall be permitted based upon medical need only, and follow-up treatment provided within sixty (60) days following either visit if related to a condition diagnosed or treated during the visits, and any care related to a pregnancy.

7.7. Cultural Considerations

The CCN shall 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 CCN shall have written procedures for the provision of language interpretation and translation services for any member who needs such services, including but not limited to, members with limited English Proficiency at no cost to the member. The provision for any needed interpretation services shall be the responsibility of the CCN.

7.8. Immunization Data

The CCN and its network providers shall utilize DHH's Louisiana Immunization Network for Kids Statewide (LINKS) web-based immunization reporting system for the reporting of all adult and child vaccinations.

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8 SERVICE ACCESSIBILITY STANDARDS

The CCN shall assist DHH in providing primary care access to all CCN members for Medicaid State Plan services through referral and coordination of such services. As it relates to primary care services, the CCN shall ensure the following:

8.1. Assurance of Adequate Access and Capacity

8.1.1. Access to PCPs

The PCP may practice in a solo or group setting or may practice in a clinic (i.e., Federally Qualified Health Center or Rural Health Clinic) or outpatient clinic. The CCN shall agree to provide at least one (1) full-time equivalent (FTE) PCP per twenty-five hundred (2,500) CCN members. The CCN shall ensure each individual PCP shall not exceed a linkage total of 2,500 Medicaid eligibles across all CCN's in which the PCP may be a network provider.

The CCN may, at its discretion, allow vulnerable populations (for example persons with multiple disabilities, acute, or chronic conditions, as determined by the CCN) to select their attending specialists as their PCP so long as the specialist is willing to perform responsibilities of a PCP and become a network provider for the CCN.

The CCN shall provide access to primary care providers that offer extended office hours (minimum of 2 hours) at least one day per week (after 5:00 pm) and on Saturdays [four (4) hours or longer]. Network providers must offer office hours at least equal to those offered to the CCN's Medicaid fee-for-service participants, if the provider accepts only Medicaid patients.

The CCN shall identify and report to the Enrollment Broker, within seven (7) calendar days, any PCP approved to provide services under the Contract that will not accept new patients or has reached capacity.

8.2. Full-time Definition

DHH defines a full time PCP as a provider that provides primary care services for a minimum of twenty (20) hours per week of practice time.

8.3. PCP/Member Ratio

The PCP to Medicaid member patient ratio (inclusive of all CCN members) shall not exceed the following unless approved in writing by DHH:

- Physician (Family Practice, General Practice, Pediatric, OB/GYN) – 1: up to 2,500;
- Nurse Practitioner (not linked to a physician group) – 1: up to 1,000;
- Physician with physician extenders (Nurse Practitioner/Physician Assistant; and Certified Nurse Midwife for OB/GYNs only) may increase basic physician ratio of 1: up to 2,500 by 1,000 per extender.

8.4. Travel Time and Distance

The CCN shall comply with the following maximum travel time and/or distance requirements, as determined by mapping software (e.g. Mapquest, Google Maps). Requests for exceptions as a result of prevailing community standards must be submitted in writing to DHH for approval.

The CCN shall ensure that in accordance with usual and customary practices primary care provider services are available on a timely basis.

8.4.1. Access to Primary Care Providers

- Travel distance for members living in rural parishes (See Appendix Q – Map of Rural Parishes) shall not exceed 30 miles; and
- Travel distance for members living in urban parishes shall not exceed 20 miles.
- Services are considered accessible if they reflect usual practice and travel arrangements in the local area. Exceptions may be approved, by DHH, if the travel distance for medical care exceeds these requirements.

8.5. Scheduling/Appointment Waiting Times

The CCN shall ensure that its network providers have an appointment system for primary care services which is in accordance with prevailing medical community standards as specified below.

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

8.6. Timely Access

8.6.1. The CCN shall ensure that medically necessary services are available on a timely basis, as follows:

- Emergent or emergency visits immediately upon presentation at the service delivery site;
- Urgent Care within twenty-four (24) hours;
- Non-urgent sick care within seventy-two (72) hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;
- Routine, non-urgent, or preventative care visits within six (6) weeks;

8.6.2. The CCN shall strive to achieve the following timeframes through the development of partnerships/relationships with FFS providers:

- Specialty care consultation within one (1) month of referral or as clinically indicated;
- Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care or as clinically indicated; and

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

8.7. Maternity Care

8.7.1. The CCN shall work with FFS provider to try to achieve the following :

8.7.1.1. An initial appointment for prenatal visits for newly enrolled pregnant women within the following timetables from the postmark date the CCN mails the member's welcome packet:

- Within their first trimester within fourteen (14) days;
- Within the second trimester with seven (7) days;
- Within their third trimester with three (3) days; and
- High risk pregnancies within three (3) days of identification of high risk by the CCN or maternity care provider, or immediately if an emergency exists;

8.7.2. Initial appointment for CCN members who become pregnant shall be within forty-two (42) days.

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9 PROVIDER SERVICES

9.1. Provider Relations

9.1.1. The CCN shall, at a minimum, provide a Provider Relations function to promote the medical home concept and provide support and assistance to all providers (both in-network and out-of-network) serving Medicaid members. This function shall:

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

9.1.1.2. Assure each CCN provider is provided all rights outlined the Provider's Bill of Rights (see Appendix K);

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

9.1.1.4. Provide ongoing provider training;

9.1.1.5. Provide responses to provider inquiries, provide general assistance to providers regarding program operations and requirements, and maintain a CCN Provider Complaint system; and

9.1.1.6. Make regularly scheduled visits to provider sites, as well as *ad hoc* visits as circumstances dictate.

9.2. Provider Toll-free Telephone Line

9.2.1. The CCN shall maintain a toll-free provider call center, physically located in the United States, with dedicated staff to respond to provider questions including, but not limited to, such topics as:

9.2.1.1. Explanation of CCN policies and procedures;

9.2.1.2. Prior authorizations;

9.2.1.3. Referrals to participating specialists;

9.2.1.4. Resolution of service and/or medical delivery problems; and

9.2.1.5. Provider grievances.

9.2.2. The CCN may utilize the same toll-free number as member services with an option for providers or may chose to secure a separate toll-free number for providers.

9.2.3. The provider toll-free telephone line must be staffed between the hours of 7am-7pm Central Time Monday through Friday to respond to provider questions in all areas, including provider complaints and provider responsibilities and on a 24/7 basis for prior authorization requests.

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

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

9.2.6. After normal business hours, the provider call center must include the capability of providing information regarding normal business hours and instructions to verify enrollment for any CCN member with an emergency or urgent medical condition. This shall not be construed to mean that the provider must obtain verification before providing emergency department services and care.

9.2.7. Performance Standards

9.2.7.1. Answer ninety (90) percent of calls within thirty (30) seconds;

9.2.7.2. Maintain an average hold time of three (3) minutes or less;

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

9.2.7.4. No more than one (1) percent of incoming calls receive a busy signal.

9.3. Website for Providers

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

9.3.2. The CCN provider website shall include general and up-to-date information about the CCN as it relates to the Louisiana Medicaid program. This shall include, but is not limited to:

- CCN Provider Manual;
- CCN-relevant DHH bulletins;
- Limitations on provider marketing;
- Information on upcoming provider trainings;
- A copy of the Provider Training Manual;
- Information on the CCN grievance system;
- Information on obtaining prior authorization and referrals; and
- Information on how to contact the CCN Provider Relations staff.

9.3.3. The CCN provider website is considered marketing material and, as such, must be reviewed and approved in writing within thirty (30) days of the date the Contract is signed by the CCN. The CCN must follow all written marketing guidelines included in this RFP and the Contract.

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

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

9.3.6. The CCN website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all

standards the Act sets for people with visual impairments and disabilities that make usability a concern.

9.4. Provider Handbooks

9.4.1. The CCN shall develop and issue a provider handbook within thirty (30) days of the date the Contract is signed by the CCN. The CCN may choose not to distribute the provider handbook via Surface Mail, provided it submits a written notification to all in-network providers that explains how to obtain the provider handbook from the CCN's website. This notification shall also detail how the provider can request a hard copy from the CCN at no charge to the provider. All provider handbooks and bulletins shall be in compliance with state and federal laws. The provider handbook shall serve as a source of information regarding CCN core benefit and services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all CCN requirements are met. At a minimum, the Provider Handbook shall include the following information:

- Description of the CCN;
- Description and requirements of NCQA Patient-Centered Medical Home recognition or JACHO Primary Home accreditation;
- Core benefits and services the CCN must provide;
- Emergency service responsibilities;
- Policies and procedures that cover the provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the CCN to file a provider complaint and which individual(s) has the authority to review a provider complaint;
- Information about the CCN's Grievance System, that the provider may file a grievance or appeal on behalf of the member, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers and the member's right to request continuation of services while utilizing the grievance system;

- Medical necessity definition as defined by DHH;
- Medical necessity review protocols and procedures;
- Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;
- PCP responsibilities;
- Other provider or contract responsibilities;
- Prior authorization and referral procedures;
- Medical records standards;
- Claims submission protocols and standards, including instructions and information necessary for a clean and complete claim and samples of clean and complete claims;
- CCN prompt pre-processing requirements (see §14);
- CCN's Chronic Care Management Program;
- Quality performance requirements; and
- Member rights and responsibilities.

9.4.2. The CCN shall disseminate bulletins as needed to incorporate any changes to the Provider Handbook.

9.4.3. Prior to the implementation of the CCN program, the CCN may opt to provide generic provider handbook information. However, the CCN shall make available to network providers a Provider Handbook specific to the CCN Program, no later than thirty (30) days after the date the CCN signs the Contract with DHH.

9.4.4. The CCN may opt not to provide a hard copy of the provider handbook to out-of-network providers, however if the CCN does not provide a hard copy the CCN must provide the website address the provider can obtain the CCN's provider handbook and related policies and procedures.

9.5. Provider Education and Training

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

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

9.5.2.1. The CCN shall provide training to out-of-network providers relative to the CCN's service authorization and pre-processing processes.

9.6. CCN Provider Complaint System

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

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

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

9.6.1.3. Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from

all parties and applying the CCN's written policies and procedures; and

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

9.6.2. The CCN shall have and implement written policies and procedures which detail the operation of the Provider Complaint System. The CCN shall submit its Provider Complaint System policies and procedures to DHH for review and approval within thirty (30) calendar days of the date the Contract with DHH is signed by the CCN. The policies and procedures shall include, at a minimum:

9.6.2.1. Allowing providers thirty (30) days to file a written complaint and a description of how providers file a complaint with the CCN and the resolution time;

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

9.6.2.3. A description of how provider relations staff are trained to distinguish between a provider complaint and an enrollee grievance or appeal in which the provider is acting on the enrollee's behalf.

9.6.2.4. A process to allow providers to consolidate complaints that involve the same or similar issues, regardless of the number of individual patients or issues included in the bundled complaint;;

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

9.6.2.6. A description of the methods used to ensure that CCN executive staff with the authority to require corrective

action are involved in the complaint process, as necessary;

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

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

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

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

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

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

9.6.5. The CCN provider shall file all appeals for the denial, reduction or suspension of medically necessary services through the state fair hearing process. See §12 of the RFP for notice of grievance and state fair hearing procedures.

9.6.5.1. Within fifteen (15) business days of the mailing of the Notice of Adverse Action, the aggrieved provider may request an administrative hearing with the Division of Administrative Law ("DAL") by filing a request for administrative hearing with the DAL. After a decision is rendered by the DAL, the aggrieved provider may seek judicial review of the DAL decision within thirty (30) days of the date the final decision is mailed to the parties, pursuant to La. R.S. 49:964. The judicial review petition shall be filed with the 19th Judicial District Court. The District Court's judgment may be appealed, by an aggrieved party, within the appeal time delays set forth in the Louisiana Code of Civil Procedure.

9.7. Materials and Information for Out-of-Network Providers

The CCN shall provide the CCN's Grievance System policies and procedures to out-of-network providers upon written or verbal request.

9.8. Reporting Requirements

The CCN shall submit to DHH monthly Provider Complaint Reports as specified by DHH.

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10 ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

DHH will contract with an Enrollment Broker who is responsible for the CCN Program's enrollment and disenrollment process for all Medicaid potential enrollees and enrollees. The Enrollment Broker shall be the primary contact for Medicaid eligibles concerning the selection of a CCN and shall assist the potential enrollee to become a member of a CCN. The Enrollment Broker shall be the only authorized entity other than DHH, to assist a Medicaid eligible in any manner in the selection of a CCN and shall be responsible for notifying all CCN members of their enrollment and disenrollment rights and responsibilities within the timeframe specified in this section.

The CCN shall abide by all enrollment and disenrollment procedures in this Section.

DHH and its agent will make every effort to ensure that recipients ineligible for enrollment in the CCN Program are not enrolled in a CCN. However, to ensure that such recipients are not enrolled in a CCN, the CCN shall assist DHH or its agent in the identification of recipients that are ineligible for enrollment in the CCN Program, should such recipients inadvertently become enrolled.

10.1. Enrollment Counseling

The Enrollment Broker will make choice counseling available to all eligible Medicaid individuals to provide assistance in selecting and enrolling into a CCN. Enrollment Broker staff will be available by telephone as appropriate to assist and provide choice counseling to CCN potential enrollees and enrollees. CCN potential enrollees and enrollees will be offered choice counseling as well as multilingual enrollment materials or materials in alternative formats, large print, and/or Braille when needed.

The Enrollment Broker's responsibilities subsequent to eligibility determination will include, but will not be necessarily be limited to, the following:

- Educating the Medicaid eligible about CCNs in general, including the requirement to enroll in a CCN, the manner in which services typically are accessed under CCNs, the role of the PCP, the responsibilities of the CCN member, and his/her right to file grievances and appeals; and the rights of the member to choose

any PCP within the CCN, subject to the capacity of the provider.

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

- Informing the member of available CCNs and outlining criteria that might be important when making a choice (e.g., presence or absence of the member's existing health care provider in a CCN's network, FQHC/RHC availability).

- Identifying any barriers to access to care for the CCN members such as:

  - Necessity for multi-lingual interpreter services, and

  - Special assistance needed for members with visual and hearing impairment and members with physical or mental disabilities.

The Enrollment Broker will inform the Medicaid potential enrollee of all CCNs available in their GSA. The Enrollment Broker shall comply with the information requirements of 42 CFR §438.10 to ensure that, before enrolling, the potential enrollee receives, from the Broker, the accurate oral and written information he or she needs to make an informed decision. This information shall be provided in accordance with Section 1932 of the Social Security Act and 42 CFR §438.104; in an objective, non-biased fashion that neither favors nor discriminates against any CCN or health care provider.

The importance of early selection of a CCN will be stressed, especially if the Medicaid potential enrollee indicates priority health needs.

The Enrollment Broker will ensure that the enrollment process is accessible to eligible Medicaid potential enrollees and enrollees by mail, internet, toll-free telephone and face-to-face for Medicaid/potential enrollees and enrollees to call and ask questions or obtain information about the enrollment process and other information, including but not limited to, available CCNs in their GSA.

To assist Medicaid potential enrollees in identifying participating providers for each CCN, the Enrollment Broker will maintain and update weekly an electronic provider directory that is accessible through the Internet and will make available, (by mail) paper provider directories including any addendums provided by the CCN upon request.

The Enrollment Broker shall be responsible for distributing all enrollment materials to all eligible Medicaid enrollees by mail and/or other suitable means.

10.1.1. Voluntary Selection of a CCN

10.1.1.1. The Enrollment Broker shall assist the Medicaid potential enrollee with the selection of a CCN that meets the potential enrollee's needs by explaining in a non-biased manner the criteria that may be considered when selecting a CCN.

10.1.1.2. Medicaid potential enrollees who are eligible for the CCN Program will have thirty (30) calendar days from the postmark date that an enrollment letter is sent to them by the Enrollment Broker to select a CCN.

10.1.1.3. All members of a family unit will be required to select the same CCN unless extenuating circumstances warrant a different CCN. Such instances must be approved by DHH or its agent or designee.

10.1.2. Automatic Assignment into CCNs

10.1.2.1. Potential enrollees/enrollees that fail to select a CCN within the thirty (30) day window shall be automatically assigned to a CCN by the Enrollment Broker in accordance with DHH's approved algorithm/formula.

10.1.2.2. The Enrollment Broker's automatic assignment methodology shall take into consideration factors, such as, but not limited to:

- The member's previous CCN;

- Inclusion in the CCN provider network of the member's historic provider as identified by Medicaid claims history;

- If the provider with which the member has a historic provider relationship contracts with more than one CCN, the member will be assigned to a CCN with which the provider contracts, on a round robin basis;

- As identified by Medicaid claims history;

- If the provider with which the family member has a current or historic provider relationship contracts with more than one CCN, the member will be assigned to a CCN with which that provider contracts, on a round robin basis;

- If neither the member nor a family member has a current or historic provider relationship, the member will be auto-assigned to a CCN with one or more PCPs accepting new patients in the member's parish of residence, on a round robin basis CCN capacity; and

- Beginning in October 2014, the CCN's quality measures will be factored into the algorithm for automatic assignment.

10.1.2.3. Neither the CCN-P Model nor the CCN-S Model will be given preference in making auto assignments.

10.1.2.4. If an entity is operating both a Prepaid and a Shared Savings Model within a GSA, it will be treated as one entity for any round robin auto assignment purposes with assignment made equally between the two.

10.1.3. <u>Automatic Re-Assignment Into CCNs</u>

10.1.3.1. Following Resumption of Eligibility

A CCN member who becomes disenrolled due to loss of Medicaid eligibility but regains Medicaid eligibility within sixty (60) calendar days will be automatically enrolled in the CCN in which the member was previously enrolled. Depending on the date eligibility is regained; there may be a gap in the member's CCN coverage. If Medicaid eligibility is regained after sixty (60) days, the reinstatement of Medicaid eligibility will prompt DHH's Enrollment Broker to mail an enrollment packet to the Medicaid potential enrollee. The Medicaid potential enrollee may also initiate the re-enrollment process without an enrollment packet.

10.1.3.2. Members Relocating to Another GSA

Members who move from one GSA to another will be automatically re-enrolled into the same CCN if the CCN is operational in that GSA. The member will have ninety (90) calendar days from the effective date of re-enrollment with the CCN to request to change CCNs for any reason.

10.1.4. CCN Lock-In Period

The CCN members shall be enrolled for a period of twelve (12) months or until their next open enrollment period, contingent upon their continued Medicaid eligibility.

Following their initial enrollment into a CCN, members have ninety (90) days from the postmark date of the Notice of Enrollment to change CCNs for any reason. Effective the ninety-first day, Medicaid enrollees/members shall be locked into the PCP assignment for a period of up to nine months beginning from the original date that he/she was assigned to the CCN.

10.1.5. Voluntary Enrollees

10.1.5.1. Voluntary potential enrollees will be given a thirty (30) day choice period to choose a CCN or opt out of the CCN program.

10.1.5.2. The Enrollment Broker will ensure that all voluntary populations will be notified at the time of enrollment of their ability to opt out without cause during the first ninety days.

10.1.5.3. Voluntary enrollees who do not opt out or proactively select a CCN will be automatically assigned to a CCN and, after the 90 day period for changing CCNs, will be locked in to the CCN for nine (9) months or until the next open enrollment unless they show cause for disenrollment from the CCN.

10.1.6. <u>Open Enrollment</u>

10.1.6.1. DHH, through its Enrollment Broker, will provide an opportunity for all CCN members to retain or select a new CCN annually during the member's annual open enrollment period. Prior to their annual open enrollment period, the Enrollment Broker will mail a re-enrollment offer to the CCN member to determine if they wish to continue to be enrolled with the CCN.

10.1.6.2. Each CCN member shall receive information and the offer of assistance with making informed choices about the CCNs in their area and the availability of choice counseling. The Enrollment Broker shall provide the member with information on the CCNs from which they may select. Each Medicaid enrollee shall be given sixty (60) calendar days to retain their existing CCN or select a new CCN.

10.1.6.3. Unless the member becomes ineligible for the CCN Program or provides written, oral or electronic notification that they no longer wish to be enrolled in the CCN, members that fail to select a new CCN during their annual open enrollment period will remain enrolled with the existing CCN.

10.1.7. <u>Suspension of and/or Limits on Enrollments</u>

10.1.7.1. The CCN shall identify the maximum number of CCN members it is able to enroll and maintain under the Contract prior to initial enrollment of Medicaid

eligibles. The CCN shall accept Medicaid enrollees as CCN members in the order in which they are submitted by the Enrollment Broker without restriction {42 CFR §438.6 (d)(1)} as specified by DHH up to the limits specified in the Contract. The CCN shall provide services to CCN members up to the maximum enrollment limits specified in the Contract. DHH reserves the right to approve or deny the maximum number of CCN members to be enrolled in the CCN based on DHH's determination of the adequacy of CCN capacity.

10.1.7.1.1. Consistent with reporting requirements in §16 of this RFP, the CCN shall submit a quarterly update of its maximum members in each GSA. The CCN shall track slot availability and notify DHH's Enrollment Broker when filled slots are within ninety (90) per cent of capacity The CCN is responsible for maintaining a record of total PCP linkages of Medicaid members and provide this information quarterly to DHH.

10.1.7.1.2. DHH will notify the CCN when the CCN's enrollment levels reach ninety-five (95) per cent of capacity and will not automatically assign Medicaid eligibles.

10.1.7.1.3. In the event the CCN's enrollment reaches sixty-five (65) percent of the total enrollment in the GSA, the CCN will not receive additional members through the automatic assignment algorithm. However, the CCN may receive new members as a result of: member choice and newborn enrollments; reassignments when a member loses and regains eligibility within a sixty (60) day period; assignments/selection when other family or case members are members of the health plan; need to ensure continuity of care for the member; or determination of just cause by DHH. DHH's evaluation of a CCN's enrollment market share shall take place on a calendar quarter.

10.1.8. CCN Enrollment Procedures

10.1.8.1. Acceptance of All Eligibles

10.1.8.1.1. The CCN shall enroll any mandatory or voluntary CCN eligible who selects it or is assigned to it regardless of the individual's age, sex, ethnicity, language needs, or health status. The only exception will be if the CCN has reached its enrollment capacity limit.

10.1.8.1.2. The CCN shall accept potential enrollees in the order in which they are assigned without restriction, up to the enrollment capacity limits set under the Contract with DHH.

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

10.1.8.1.4. Identifying any sources of third party liability which were not identified by the financial eligibility case worker.

10.1.8.2. Effective Date of Enrollment

Enrollment, whether chosen or auto-assigned, will be effective at 12:01 A.M. on the first (1st) calendar day of the month following the Member selection or Auto-Assignment, for those members assigned on or before the third (3rd) to last working day of a given month will be effective 12:01AM on the first (1st) calendar day of the month following assignment. For those

members assigned after the third (3rd) to last working day in a given month, enrollment will be effective at 12:01 A.M. on the first (1st) calendar day of the second (2nd) month following assignment.

10.1.8.3. Change in Status

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

10.1.9. Newborn Enrollment

10.1.9.1. The CCN shall contact members who are expectant mothers sixty (60) calendar days prior to the expected date of delivery to encourage the mother to choose a CCN and a PCP for her newborn.

10.1.9.2. The CCN should work with hospitals to report the births of newborns within twenty-four (24) hours of birth for enrolled members using DHH's web-based Request for Newborn ID system. If the mother has made a CCN and/or PCP selection, this information shall be reported. If no selection is made, the newborn will be automatically enrolled in the mother's CCN. Enrollment of newborns shall be retroactive to the date of the birth.

10.1.10. Assignment of Primary Care Providers

10.1.10.1. Member Selects PCP during Enrollment

As part of the initial enrollment Medicaid application process, applicants may be given the option to indicate their preferred choice of CCN and PCP.

10.1.10.1.1. If the choice of CCN and PCP is not indicated on the new eligible file transmitted by DHH to

the Enrollment Broker, the Enrollment Broker shall contact the eligible individual to request their choice of CCN and if available the PCP of choice.

10.1.10.1.2. The Enrollment Broker shall encourage the continuation of any existing satisfactory provider/patient relationship with their current PCP who is in a CCN.

10.1.10.1.3. The name of PCP requested by a new enrollee will be included in the Member File from the Enrollment Broker to CCN.

10.1.10.1.4. The CCN shall confirm the PCP selection information in a written notice to the member.

10.1.10.1.5. If no PCP is selected on the Member File received from the Enrollment Broker, the CCN will:

a. Contact the member, as part of the welcome packet, within ten (10) business days of receiving the Member File from the Enrollment Broker to assist the member in making a selection of a PCP.

10.1.10.1.6. The CCN shall inform the member that each family member has the right to choose his/her own PCP. The CCN may explain the advantages of selecting the same primary care provider for all family members, as appropriate.

10.1.10.1.7. Members who do not proactively choose a PCP within ten (10) days of enrollment with a CCN will be auto-assigned to a PCP by the CCN.

10.1.10.1.8. The CCN shall have written policies and procedures for handling the assignment of its members to a primary care provider. The CCN

is responsible for linking all Medicaid enrollees to a primary care provider.

10.1.10.2. Automatic Assignments by CCN

10.1.10.2.1. The CCN is responsible for developing a PCP automatic assignment methodology in collaboration with DHH to assign an enrollee to a PCP when the enrollee:

- Does not make a PCP selection after a voluntary selection of a CCN; or
- Selects a PCP within the CCN that has reached their maximum physician/patient ratio; or
- Selects a PCP within the CCN that has restrictions/limitations (e.g. pediatric only practice).

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

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

The CCN and PCP automatic assignment methodology must be submitted, within thirty (30) days after the Contract is signed by the

CCN, for approval by DHH prior to implementation. This methodology must be shared with subcontractors and members prior to enrollment.

10.1.10.2.4. The CCN shall be responsible for providing to the Enrollment Broker, information on the number of Medicaid member linkages and remaining capacity of each individual PCP of additional Medicaid member linkages n a quarterly basis.

10.1.10.2.5. If the member does not select a PCP and is auto assigned to a PCP by the CCN, the CCN shall allow the member to change PCP, at least once, during the first ninety (90) days from assignment to the PCP without cause.

10.1.10.2.5.1. Effective the ninety-first (91st) day, the member may be locked into the assignment to the selected PCP for a period of up to twelve (12) months beginning from the original date the member was assigned to the CCN.

10.1.10.2.6. If a member requests to change his or her PCP with cause, at any time during the enrollment period, the CCN must grant the request.

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

of PCP to members and shall provide information on options for selecting a new PCP. The CCN shall have policies for accessing emergency/urgent care during this transition period. These policies and procedures shall be submitted within thirty (30) days from the date the CCN signs the contract with DHH.

10.1.10.2.8. The CCN shall notify the Enrollment Broker by close of business the next business day of a PCP's termination.

10.1.11. Disenrollment

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

The Enrollment Broker shall be the single point of contact to the CCN member for notification of disenrollment.

10.1.11.1. <u>Member Initiated Request</u>

A member or his/her representative must submit an oral or written request to the Enrollment Broker to disenroll from a CCN. The member may disenroll for the following reasons:

10.1.11.1.1. For cause, at any time. The following circumstances are cause for disenrollment:

- The member moves out of the CCN's designated service area;

- The CCN does not, because of moral or religious objections, cover the service the member seeks;

- The member requests to be assigned to the same CCN as family members;

- The member needs related services to be performed at the same time, not all related services are available within the CCN and the member's PCP or another provider determines that receiving the services separately would subject the ember to unnecessary risk;

- If DHH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a)(3).

- The contract between the CCN and DHH is terminated; and

- Other reasons including, but not limited to:

    - Poor quality of care;

    - Lack of access to CCN core benefits and services covered under the Contract;

    - Documented lack of access within the CCN to providers experienced in dealing with the member's healthcare needs; or

    - Any other reason deemed to be valid by DHH and/or its agent.

10.1.11.1.2. Without cause for the following reasons:

- During the 90 day opt-out period following initial enrollment with the CCN for voluntary members;
- During the 90 days following the postmark date of the member's notification of enrollment with the CCN;
- Once a year thereafter during the member's annual open enrollment period;
- Upon automatic re-enrollment under 42 CFR §438.56(g), if a temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or
- If DHH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a)(3).

10.1.11.1.3. The member (or his/ her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.

10.1.11.1.4. If the member's request for disenrollment is denied by the Enrollment Broker, the member can appeal directly to the State Fair Hearing process.

10.1.11.2. **<u>CCN Initiated Request</u>**

10.1.11.2.1. The CCN shall submit requests for involuntary disenrollment of a member that includes, at a minimum, the member's name, ID number, and detailed reasons for requesting the disenrollment utilizing the CCN Request for Member Disenrollment to the Enrollment Broker (See Appendix L). The CCN shall not request disenrollment for reasons other than those stated in this RFP

and the Contract. (See Appendix M – Guidelines for Member Disenrollment)

10.1.11.2.2. The following are allowable reasons for which the CCN may request involuntary disenrollment of a member:

- A member's fraudulent use of the CCN's ID card. (e.g. The member misuses or loans the member's CCN-issued ID card to another person to obtain services.) In such cases the CCN shall report the event to the Medicaid Program Integrity Section; and

- The member's behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the CCN seriously impairs the organization's ability to furnish services to either the member or other members and the member's behavior is not caused by a physical or mental health condition.

    - The CCN shall take reasonable measures to correct member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

10.1.11.2.3. The CCN shall promptly submit such disenrollment requests to the Enrollment Broker. The CCN shall not submit a disenrollment request at such a date as would cause the disenrollment to be effective earlier than forty-five (45) calendar days after the occurrence of the event prompting the request for involuntary disenrollment. The CCN shall ensure that involuntary disenrollment

documents are maintained in an identifiable member record.

10.1.11.2.4. All requests will be reviewed on a case-by-case basis and are subject to the sole discretion of DHH or its designee (Enrollment Broker). All decisions are final and not subject to the discussion.

10.1.11.2.5. DHH approved disenrollment requests shall be assisted and completed by the Enrollment Broker and in a manner so designated by DHH.

10.1.11.2.6. When the CCN requests an involuntary disenrollment, it shall notify the member in writing that the CCN is requesting disenrollment, the reason for the request, and an explanation that the CCN is requesting that the member be disenrolled in the month following member notification, or earlier if necessary. Until the enrollee is disenrolled by the Enrollment Broker, the CCN shall be responsible for the provision of services to that member.

- The Enrollment Broker will provide written notice of disenrollment to the member and request that the member choose a new CCN. The notice shall include a statement that if the member disagrees with the decision to disenroll the member from the CCN, the member has a right to file an appeal directly through the State Fair Hearing process.

10.1.11.2.7. Until the member is disenrolled by the Enrollment Broker, the CCN shall continue to be responsible for the provision of all core benefits and services to the member.

10.1.11.2.8. The CCN shall not request disenrollment because of the following:

- A member's health diagnosis;
- Adverse change in health status;
- Utilization of medical services;
- Diminished medical capacity;
- Pre-existing medical condition;
- Refusal of medical care or diagnostic testing;
- Uncooperative or disruptive behavior resulting from him or her special needs, unless it seriously impairs the CCN's ability to furnish services to either this particular member or other members as defined in this RFP; or
- The member attempts to exercise his/her rights under the CCN's grievance system, or attempts to exercise her/her right to change, for cause, the primary care provider that he/she has chosen or been assigned.

10.1.11.3. **DHH Initiated Disenrollment**

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

10.1.11.3.1. Loss of Medicaid eligibility or loss of CCN enrollment eligibility;

10.1.11.3.2. Death of a member;

10.1.11.3.3. Member's intentional submission of fraudulent information;

10.1.11.3.4. Member is incarcerated;;

10.1.11.3.5. Member moves out-of-state;

10.1.11.3.6. Member becomes Medicare eligible;

10.1.11.3.7. Member is placed in a long term care facility (nursing facility or intermediate care facility for persons with developmental disabilities);

10.1.11.3.8. Member is enrolled in a Medicaid home and community-based services waiver(HDBS) ;

10.1.11.3.9. Member elects to receive hospice services;

10.1.11.3.10. Member requests to be assigned to the same CCN as family members;

10.1.11.3.11. The member needs related services to be performed at the same time, not all related services are available within the CCN and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk;

10.1.11.3.12. The Contract between the CCN and DHH is terminated;

10.1.11.3.13. The member loses Medicaid eligibility;

10.1.11.3.14. The members eligibility changes to an excluded eligibility group;

10.1.11.3.15. To implement the decision of a hearing officer in an appeal proceeding by the member against the CCN or as ordered by a court of law.

10.1.11.4. **<u>Disenrollment Effective Date</u>**

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

10.1.11.4.2. If DHH or its designee fails to make a disenrollment determination by the first day of the second month following the month in which the request for disenrollment is filed, the disenrollment is considered approved.

10.1.11.4.3. DHH, the CCN, and the Enrollment Broker shall reconcile enrollment/disenrollment issues at the end of each month utilizing an agreed upon procedure.

10.1.11.5. <u>Transition of Enrollment</u>

10.1.11.5.1. The CCN must provide active assistance to members when transitioning to another CCN or back to the Medicaid FFS program.

10.1.11.5.2. The receiving CCN shall be responsible for the provision of medically necessary services covered under the Contract that are required for the member during the transition period.

10.1.11.5.3. The transition period shall not exceed thirty (30) calendar days from the effective date of the member's enrollment in the receiving CCN.

10.1.11.5.4. During this transition period, the receiving CCN shall be responsible for notification to the new PCP of member's selection, initiation of the request of transfer for the member's medical files, arrangement of medically necessary services (if applicable) and all other requirements for new members.

10.1.11.5.5. If a member is to be transferred between CCNs but is hospitalized at the time, the transfer shall be effective for the date of enrollment into the receiving CCN. However, the relinquishing CCN shall notify the receiving CCN of the member's

hospitalization status within five (5) business days.

10.1.11.5.6. Upon notification of the member's transfer, the receiving CCN shall request copies of the member's medical record, unless the member has arranged for the transfer.

a. The previous CCN shall transfer a copy of the member's complete medical record and allow the receiving CCN access (immediately upon request) to all medical information necessary for the care of that member.

b. Transfer of records shall not interfere or cause delay in the provision of services to the member.

- The cost of reproducing and forwarding medical records to the receiving CCN shall be the responsibility of the relinquishing CCN.

- A copy of the member's medical record and supporting documentation shall be forwarded by the relinquishing CCN's PCP within ten (10) business days of the receiving CCN's PCP's request.

c. The CCN shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the CCN, regardless of whether such services are provided by an in-network or out-of-network provider, however, the CCN may require prior authorization of services beyond thirty (30) calendar days.

- During transition the CCN is prohibited from denying prior

authorization solely on the basis of the provider being an out-of-network provider.

10.1.12. Enrollment and Disenrollment Updates

DHH's Enrollment Broker will notify each CCN at specified times each month of the Medicaid eligibles that are enrolled, re-enrolled, or disenrolled from the CCN for the following month. The CCN will receive this notification through electronic media.

DHH will use its best efforts to ensure that the CCN receives timely and accurate enrollment and disenrollment information. In the event of discrepancies or irresolvable differences between DHH and the CCN regarding enrollment, disenrollment and/or termination, DHH's decision is final.

10.1.12.1. Daily Updates

The Enrollment Broker shall make available to the CCN daily via electronic media, updates on members newly enrolled into the CCN in the format specified in the ***CCN-S Systems Companion Guide***. The CCN shall have written policies and procedures for receiving these updates, incorporating them into its management information system and ensuring this information is available to its providers. Policies and procedures shall be available for review at the pre-implementation Readiness Review.

10.1.12.2. Weekly Reconciliation

10.1.12.2.1. Enrollment

The CCN is responsible for weekly reconciliation of the membership list of new enrollments and disenrollments received from the Enrollment Broker against its internal records. The CCN shall provide written notification to the Enrollment Broker of any

data inconsistencies within 10 calendar days of receipt of the data file.

10.1.12.2.2. Payment

The CCN will receive an electronic file from the Medicaid Fiscal Intermediary (FI) listing all members for whom the CCN received a PMPM payment and the amount received. The CCN is responsible for reconciling this listing against its internal records. (See Appendix N for FI Payment Schedule) It is the CCN's responsibility to notify the FI of any discrepancies. Lack of compliance with reconciliation requirements will result in the withholding of portion of future monthly payments and/or monetary penalties as defined Section §18 of this RFP, until requirements are met.

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11 MARKETING AND MEMBER EDUCATION

11.1. General Guidelines

11.1.1. Marketing, for purposes of this RFP, is defined in 42 CFR §438.104 (a) as any communication from a CCN to a Medicaid eligible who is not enrolled in that CCN that can reasonably be interpreted to influence the recipient to 1) enroll in that particular CCN's Medicaid product, or 2) either not enroll in, or disenroll from, another CCN's Medicaid product.

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

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

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

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

11.1.6. All marketing and member education guidelines specified in this subsection are applicable to the CCN, its agents, subcontractors, volunteers and/or providers.

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

11.1.8. All marketing and member education materials and activities shall comply with the requirements in 42 CFR § 438.10 and the DHH requirements set forth in this RFP.

11.1.9. The CCN is responsible for creation, production and distribution of its own marketing and member education materials to its enrollees. DHH and the DHH Enrollment Broker will only be responsible for distributing general material developed and produced by the CCN for inclusion in the enrollment package distributed to Medicaid enrollees. DHH will determine which materials will be included in the Enrollment Broker generated packet and which materials will be distributed by the CCN.

11.1.10. Under the Louisiana CCN Program, all direct marketing to eligibles or potential eligibles will be performed by DHH or its designee in accordance with 1932 (d)(2 A) of the Social Security Act as amended and 42 CFR §438.104.

11.1.11. Activities involving distribution and completion of a CCN enrollment form during the course of enrollment activities is an enrollment function and is the sole responsibility of DHH's Enrollment Broker.

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

11.2. <u>Marketing and Member Education Plan</u>

11.2.1. The CCN shall develop and implement a plan detailing the marketing and member education activities it will undertake and materials it will create during the Contract period, incorporating DHH's requirements for participation in the CCN Program. The detailed plan must be submitted to DHH for review and approval within thirty (30) calendar days from the date the Contract is signed by the CCN.

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

11.2.3. The CCN should develop a separate marketing and member education plan for each GSA in which it plans to participate. The CCNs' plan shall take into consideration projected enrollment levels for equitable coverage of the entire CCN service area. The plan should clearly distinguish between marketing activities and

materials and member education activities and materials. The plan shall include, but is not limited to:

11.2.3.1. Stated marketing goals and strategies;

11.2.3.2. A marketing and member education calendar, which begins with the date of the signed Contract by the CCN and runs through the first calendar year of providing services to Medicaid enrollees, that addresses all marketing areas: advertising plans, coverage areas, Web site development and launch plans, printed materials, material distribution plans (including specific locations), outreach activities (health fairs, area events, etc.);

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

11.2.3.4. The CCN's plans for new member outreach, including welcome packets and welcome call;

11.2.3.5. The CCN's plan to incorporate the CMS "Text 4 Baby" initiative, a free mobile health service that provides health information through SMS text messages to pregnant women and new mothers during the baby's first year. Information on the program is available at www.text4baby.org ;

11.2.3.6. The CCN's plans to meet the informational needs, relative to marketing (for prospective enrollees) and member education (for current enrollees), for the physical and cultural diversity of the GSA. This may include, but is not limited to: a description of provisions for non-English speaking prospective enrollees, interpreter services, alternate communication mechanisms (such as sign language, Braille, audio tapes);

11.2.3.7. A list of all subcontractors engaged in marketing or member education activities for the CCN;

11.2.3.8. A copy of the CCN training curriculum for marketing representatives (both internal and subcontractor);

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

11.2.3.10. Copies of all marketing and member education materials (print and multimedia) the CCN or any of its subcontractor's plan to distribute that are directed at Medicaid eligibles or potential eligibles. All materials must be submitted in the plan with the DHH Marketing and Member Education Materials Approval Form (See Appendix O);

11.2.3.11. Copies of marketing and member education materials that are 1) currently in concept form, but not yet produced (should include a detailed description) or 2) samples from other states that will be duplicated in a similar manner for the Louisiana CCN population. These materials do not require a DHH Marketing and Member Education Materials Approval Form as they must be resubmitted in final draft before obtaining approval by DHH;

11.2.3.12. Details of proposed marketing and member education activities and events. All activities must be submitted in the plan using the DHH Event Submission Form (See Appendix P);

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

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

11.2.3.15. The CCN's protocol for responding to unsolicited direct contact (verbal or written) from a potential member (the CCN is not allowed to engage in

marketing encounters with potential members, but Medicaid enrollees may seek out specific CCNs for information).This should include:

- Circumstances that will initiate referral to the Enrollment Broker;
- Circumstances that will initiate referral to the Medicaid Customer Service Line (toll free #1-888-342-6207);
- Circumstances that will terminate the encounter; and
- Circumstances that will prompt the CCN to distribute materials to the potential member and a draft of those materials (which must refer all enrollment inquiries to the Enrollment Broker).

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

11.3. <u>Prohibited Activities</u>

The CCN and its subcontractors are prohibited from in engaging in the following activities:

11.3.1. Marketing directly or indirectly to Medicaid potential enrollees or CCN prospective enrollees, including persons currently enrolled in Medicaid or other CCNs (including direct mail advertising, "spam", door-to-door, telephonic, or other "cold call" marketing techniques);

11.3.2. Asserting that the CCN is endorsed by CMS, the federal or state government or similar entity;

11.3.3. Distributing plans and materials or making any statement (written or verbal) that DHH determines to be inaccurate, false, confusing, misleading or intended to defraud members or DHH. This includes statements which mislead or falsely describe covered services, membership or availability of providers and qualifications and skills of providers and assertions the recipient

of the communication must enroll in a specific plan in order to obtain or not lose benefits;

Falsely implying that Medicaid members will have access to the same benefits and providers as a CCN's commercial members;

11.3.3.1. Distributing marketing information (written or verbal) that falsely implies that a Medicaid member will be able to stay with their longtime doctor;

11.3.4. Portraying competitors or potential competitors in a negative manner;

11.3.5. Attaching a Medicaid application and/or enrollment form to marketing materials;

11.3.6. Assisting with enrollment or improperly influencing CCN selection;

11.3.7. Inducing or accepting a member's enrollment or disenrollment;

11.3.8. Using the seal of the state of Louisiana, DHH's name, logo or other identifying marks on any materials produced or issued, without the prior written consent of DHH;

11.3.9. Distributing marketing information (written or verbal) that falsely implies that a Medicaid member will be able to stay with their longtime doctor;

11.3.10. Distributing marketing information (written or verbal) that implies that joining CCNs or a particular CCN is the only means of preserving Medicaid coverage or that CCNs or a particular CCN is the only provider of Medicaid services and the potential enrollee must enroll in the CCN or CCNs to obtain benefits or not lose benefits;

11.3.11. Comparing their CCN to another organization/CCN by name;

11.3.12. Sponsoring or attending any marketing or community health activities or events without notifying DHH within the timeframes specified in this RFP;

11.3.13. Engaging in any marketing activities, including unsolicited personal contact with a potential enrollee, at an employer-sponsored enrollment event where employee participation is mandated by the employer;

11.3.14. Offering any gifts or material (either provided by the CCN or a third party source) with financial value, or financial gain as incentive to or conditional upon enrollment. Promotional items having no substantial resale value ($15.00 or less in value) are not considered things of financial value. Cash gifts of any amount, including contributions made on behalf of people attending a marketing event, gift certificates or gift cards are not permitted to be given to beneficiaries or the general public;

11.3.15. Making reference to any health-related rewards offered by the plan (such as monetary rewards for participation in smoking cessation) in pre-enrollment marketing materials;

11.3.16. Marketing or distributing marketing materials, including member handbooks, and soliciting members in any other manner, within one hundred (100) feet or inside the office or in front of the building and the nearest paved or unpaved road of check cashing establishments, public assistance offices, /DCFS eligibility offices for the Supplemental Nutrition Assistance Program (SNAP), FITAP, Medicaid Eligibility Offices and/or certified Medicaid Application Centers. Medicaid Eligibility Office staff or approved DHH agents shall be the only authorized personnel to distribute such materials;

11.3.17. Conducting marketing or distributing marketing materials in hospital emergency rooms, including the emergency room waiting areas, patient rooms or treatment areas;

11.3.18. Copyrighting or releasing any report, graph, chart, picture, or other document produced in whole or in part relating to services provided under this Contract on behalf of the CCN without the prior written consent of DHH;

11.3.19. Purchasing or otherwise acquiring or using mailing lists of Medicaid eligibles from third party vendors, including providers and state offices;

11.3.20. Using raffle tickets or event attendance or sign-in sheets to develop mailing lists of prospective enrollees;

11.3.21. Charging members for goods or services distributed at events;

11.3.22. Charging members a fee for accessing the CCN Web site;

11.3.23. Influencing enrollment in conjunction with the sale or offering of any private insurance;

11.3.24. Using a personal or provider-owned communication device (such as a. telephone or cell phone, fax machine, computer) to assist a person in enrolling in a CCN;

11.3.25. Using terms that would influence, mislead or cause potential members to contact the CCN, rather than the DHH-designated Enrollment Broker, for enrollment;

11.3.26. Making charitable contributions or donations from Medicaid funds;

11.3.27. Referencing the commercial component of the CCN in any of its Medicaid CCN enrollee marketing materials, if applicable; and

11.3.28. Using terms in marketing materials such as "choose," "pick," "join," etc. unless the marketing materials include the Enrollment Broker's contact information.

11.4. **Allowable Activities**

In any instance where a CCN allowable activity conflicts with a prohibited activity, the prohibited activity guidance should be followed.

The CCN and its subcontractors shall be permitted to perform the following activities:

11.4.1. Distribute general information through mass media (i.e. newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, billboards and other media outlets) in keeping with prohibitions to placement as detailed in this RFP;

11.4.2. Make telephone calls and home visits only to members currently enrolled in the CCN's plan (member education and outreach) for the sole purpose of educating them about services offered by or available through the CCN;

11.4.3. Respond to verbal or written requests for information made by potential members in keeping with the response plan outlined in the marketing plan approved by DHH prior to response.;

11.4.4. Provide promotional giveaways that exceed the $15.00 value to current members only;

11.4.5. Attend or organize activities that benefit the entire community such as health fairs or other health education and promotion activities. Notification to DHH must be made of the activity and details must be provided about the planned marketing activities;

11.4.6. Attend activities at a business at the invitation of the entity. Notification to DHH must be made of the activity and details must be provided about the planned marketing activities;

11.4.7. Conduct telephone marketing only during incoming calls from potential members. The CCN may return telephone calls to potential members only when requested to do so by the caller. All telephone inquiries related to applying for Medicaid must be referred to the DHH toll free Customer Service Unit (toll free #1-888-342-6207). All inquires related to enrolling in a CCN must be referred to the Enrollment Broker toll free number; and

11.4.8. Send plan-specific materials to potential members at the potential member's request.

11.5. <u>Marketing and Member Education Materials Approval Process</u>

11.5.1. The CCN must obtain prior written approval from DHH for all marketing and member education materials for potential or current enrollees. This includes, but is not limited to, print, television and radio advertisements; member handbooks, identification cards and provider directories; CCN website screen shots; promotional items; brochures; letters and mass mailings and e-mailings. Neither the CCN nor its

subcontractors may distribute any CCN marketing or member education materials without DHH consent.

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

11.5.2.1. Materials submitted as part of the original marketing and member education plan will be considered approved with the approval of the plan if the materials were in final draft form.

11.5.3. CCNs must obtain prior written approval for all materials developed by a recognized entity having no association with the CCN that the CCN wishes to distribute. DHH will only consider materials when submitted by the CCN (not subcontractors).

11.6. <u>Review Process – Materials</u>

11.6.1. DHH will review the submitted marketing and member education materials and either approve, deny or submit changes within thirty (30) days from the date of submission;

11.6.2. Once member materials are approved in writing by DHH, the CCN shall submit an electronic version (PDF) of the final printed product, unless otherwise specified by DHH, within 10 calendar days from the print date. If DHH requests that original prints be submitted in hard copy, photo copies may not be submitted for the final product. Upon request, the CCN must provide additional original prints of the final product to DHH;

11.6.3. Prior to modifying any approved member material, the CCN shall submit for written approval by DHH, a detailed description of the proposed modification accompanied by a draft of the proposed modification;

11.6.4. DHH reserves the right to require the CCN to discontinue or modify any marketing or member education materials after approval;

11.6.5. CCN materials used for the purpose of marketing and member education, except for the original CCN marketing and member education plan, are deemed approved if a response from DHH is not returned within thirty (30) calendar days following receipt of materials by DHH; and

11.6.6. The CCN must review all marketing and member education materials on an annual basis and revise materials, if necessary, to reflect current practices. Any revisions must be approved by DHH prior to distribution.

11.7. **Marketing and Member Education Materials Event and Activities Approval Process**

11.7.1. The CCN must obtain prior written approval from DHH for all marketing and member education events and activities for potential or current enrollees as well as any community/health education activities that are focused on health care benefits (health fairs or other health education and promotion activities). Neither the CCN nor its subcontractors may participate in any such activities or events without DHH consent.

11.7.2. All proposed events and activities must be submitted to DHH utilizing the DHH Event Submission Form. (See Appendix P)

Activities and events submitted as part of the original marketing and member education plan will be considered approved with the approval of the plan if the activity or event details are complete.

11.7.3. **Review Process – Events and Activities**

- DHH will review the submitted marketing and member education events and activities and either approve or deny within thirty (30) calendar days from the date of submission.

- DHH will review the submitted community/health education events and activities and either approve or deny within seven (7) calendar days from the date of submission.

- DHH reserves the right to require the CCN to discontinue or modify any marketing or member education events after approval.

- Marketing and member education events and activities, except for those included in the original CCN marketing and member education plan, are deemed approved if a response from DHH is not returned within thirty (30) calendar days following notice of event to DHH.

- Community/health education events and activities except for those included in the original CCN marketing and member education plan, are deemed approved if a response from DHH is not returned within seven (7) calendar days following notice of event to DHH.

- Any revisions to approved events and activities must be resubmitted for approved by DHH prior to the event or activity.

11.8. <u>CCN Provider Guidelines</u>

11.8.1. When conducting any form of marketing in a provider's office, the CCN must acquire and keep on file the written consent of the provider.

11.8.2. The CCN may not require its providers to distribute CCN-prepared communications to their patients.

11.8.3. The CCN may not provide incentives or giveaways to providers to distribute them to CCN members or potential CCN members.

11.8.4. The CCN may not conduct member education in common areas of provider offices.

11.8.5. The CCN may not allow providers to solicit enrollment or disenrollment in a CCN, or distribute CCN-specific materials at a marketing activity.

11.8.6. The CCN shall instruct participating providers regarding the following communication requirements:

- Participating providers who wish to let their patients know of their affiliations with one or more CCNs must list each CCN with whom they have contracts;

- Participating providers may display and/or distribute health education materials for **all** contracted CCNs or they may choose not to display and/or distribute for **any** contracted CCNs. Health education materials must adhere to the following guidance:

  - Health education posters cannot be larger than 16" X 24";

  - Children's books, donated by CCNs, must be in common areas;

  - Materials may include the CCNs name, logo, phone number and Web site; and

  - Providers are not required to distribute and/or display all health education materials provided by each CCN with whom they contract. Providers can choose which items to display as long as they distribute items from each contracted CCN and that the distribution and quantity of items displayed are equitable.

- Providers may display marketing materials for CCNs provided that appropriate notice is conspicuously and equitably posted, in both size of material and type set, for all CCNs with whom the provider has a subcontract.

- Providers may display CCN participation stickers, but they must display stickers by **all** contracted CCNs or choose to not display stickers for **any** contracted CCNs.

- CCN stickers indicating the provider participates with a particular health plan cannot be larger than 5" x 7" and not indicate anything more than "the health plan or CCN is accepted or welcomed here."

- Providers may inform their patients of the benefits, services and specialty care services offered through the

CCNs in which they participate. However, providers may not recommend one CCN over another CCN, offer patients incentives for selecting one CCN over another, or assist the patient in deciding to select a specific CCN.

- Upon termination of a subcontract with the CCN, a provider that has contracts with other CCNs may notify their patients of the change in status and the impact of such a change on the patient.

11.9. CCN Marketing Representative Guidelines

11.9.1. All CCN marketing representatives, including subcontractors assigned to marketing, must successfully complete a training program about the basic concepts of Louisiana Medicaid, CCNs and the enrollees' rights and responsibilities relating to enrollment in CCNs and grievance and appeals rights.

11.9.2. The CCN shall ensure that all marketing representatives engage in professional and courteous behavior. The CCN shall not participate, encourage or accept inappropriate behavior by its marketing representatives, including but not limited to interference with other CCN presentations or talking negatively about other CCNs.

11.9.3. The CCN shall not offer compensation to a marketing representative, including salary increases or bonuses, based solely on an overall increase in CCN enrollment. Compensation may be based on periodic performance evaluations which consider enrollment productivity as one of several performance factors.

11.9.4. Sign-on bonuses for marketing representatives are prohibited.

11.9.5. The CCN shall keep written documentation of the basis it uses for awarding bonuses or increasing the salary of marketing representatives and employees involved in marketing and make such documentation available for inspection by DHH.

11.10. Written Material Guidelines

The CCN must comply with the following requirements as it relates to all written member materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.):

11.10.1. All member materials must be in a style and reading level that will accommodate the reading skills of CCN Enrollees. In general the writing should be at no higher than a sixth-grade (6.9) reading level, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy and in accordance with DHH's Person First Policy. (See Appendix EE) The text must be printed in at least twelve point font, preferably twelve-point font. DHH reserves the right to require evidence that a handbook has been tested against the sixth-grade reading-level standard;

11.10.2. If a person making a testimonial or endorsement for a CCN has a financial interest in the company, such fact must be disclosed in the marketing materials;

11.10.3. All written materials must be clearly legible with a minimum font size of 12 point, with the exception of member ID cards, unless otherwise approved by DHH;

11.10.4. The quality of materials used for printed materials shall be, at a minimum, equal to the materials used for printed materials for the CCN's commercial plans if applicable;

11.10.5. The CCNs name, mailing address (and physical location, if different) and toll-free number must be prominently displayed on the cover of all multi-paged marketing materials;

11.10.6. Translation services must be provided for written marketing and member education materials for any language that is spoken as a primary language for 200 or more members of a CCN within the GSA. Within ninety (90) calendar days of notice from DHH, materials must be translated and made available;

11.10.7. All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services;

11.10.8. All written materials related to CCN and PCP enrollment shall advise potential enrollees to verify with the medical services providers they prefer or have an existing relationship with, that

such medical services providers are participating providers of the selected CCN and are available to serve the enrollee;

11.10.9. Alternative forms of communication, upon request, must be provided for persons with visual, hearing, speech, physical or developmental disabilities. These alternatives must be provided at no expense to the member;

11.10.10. Marketing materials must be made available through the CCN's entire service area. Materials may be customized for specific parishes and populations within the CCNs service area;

11.10.11. All marketing activities should provide for equitable distribution of materials without bias toward or against any group; and

11.10.12. Marketing materials must accurately reflect general information, which is applicable to the average potential member of the CCN.

11.11. <u>CCN Website Guidelines</u>

11.11.1. The CCN website must include general and up-to-date information about its CCN as it relates to the Louisiana Medicaid program. This may be developed on a page within its existing website to meet these requirements.

11.11.2. The CCN must notify DHH when the website is in place, which has been approved by DHH, and when approved updates are made.

11.11.3. The CCN must remain -compliant with HIPAA privacy and security requirements when providing member eligibility or member identification information on the website.

11.11.4. The CCN website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern. The CCN web site must follow all written marketing guidelines included in this Section.

11.11.5. Use of proprietary items that would require a specific browser is not allowed.

11.11.6. The CCN must provide the following information on its website, and such information shall be easy to find, navigate, and understand by all members:

- The most recent version of the Member Handbook;
- Telephone contact information, including a toll-free customer service number prominently displayed and a Telecommunications Device for the Deaf (TDD) number;
- A searchable list of network providers with a designation of open versus closed panels, updated immediately upon changes to the network;
- The link to the Enrollment Broker's website and toll free number for questions about enrollment'
- The link to the Medicaid website (www.medicaid.dhh.louisiana.gov) and the toll free number (888-342-6206) for questions about Medicaid eligibility.
- The capability for members to submit questions and comments to the CCN and receive responses;
- A section for the CCN's providers that includes contact information, claims submittal information, prior authorization instructions, and local and toll-free telephone numbers;
- General customer service information; and
- Information on how to file grievances and appeals.

11.12. <u>Member Education – Required Materials and Services</u>

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

11.12.1. New Member Orientation

11.12.1.1. The CCN shall have written policies and procedures for the following, but not limited to:

- Orienting new members of its benefits and services;
- Role of the PCP;
- What to do during the transition period, (e.g. How to access services, continue medications, and obtain emergency or urgent medical services when transferring from FFS or CommunityCARE 2.0 to CCN, or from one CCN to another, etc);
- How to utilize services;
- What to do in an emergency or urgent medical situation; and
- How to a file a grievance and appeal.

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

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

11.12.1.4. DHH's Enrollment Broker shall send the CCN a daily eligibility file. The file shall contain the names, addresses and, as available phone numbers and email addresses, of all newly eligible enrollees assigned to the CCN with an indicator for individuals who are automatically assigned to the CCN. The file will include the name of the preferred PCP if affirmative choice made; for automatic assignments, the file will include the name of the most recent CommunityCARE 2.0 PCP if applicable. The CCN shall use the file to assign PCPs and to identify new members to whom the CCN shall send a welcome packet and conduct a welcome phone call.

11.12.1.5. The CCN shall have written policies and procedures for notifying new members within ten (10) business days after receiving notification from the Enrollment Broker of enrollment. This notification must be in writing and

include a listing of names, locations, and office telephone numbers that the enrollee may choose as their primary care provider if the file did not contain a PCP selected by the member.

11.12.1.6. The CCN shall submit a copy of the procedures to be used to contact CCN members for initial member education to DHH for approval within thirty (30) days following the date the Contract is signed by the CCN. These procedures shall adhere to the enrollment process and procedures outlined in this RFP and the Contract.

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

11.13. Communication with New Enrollees

DHH's Enrollment Broker shall send the CCN a daily eligibility file in the format specified in the **CCN Systems Companion Guide**.

11.13.1. Welcome Packets

- The CCN shall send a welcome packet to new members within ten (10) business days from the date of receipt of the file from DHH or the Enrollment Broker identifying the new enrollee. During the enrollment phase-in implementation (January 2012 – May 2012) of the CCN program, the CCN may have up to twenty-one (21) days to provide welcome packets.

- The CCN must mail a welcome packet to the responsible party for each new member. When the family head of household or enrollee name is associated with two (2) or more new members, the CCN is only required to send one welcome packet.

- All contents of the welcome packet are considered member education materials and, as such, shall be reviewed and approved in writing by DHH prior to distribution according to the provisions in this RFP. Contents of the welcome packets shall include those items specified in the Contract. The welcome packet shall include, but is not limited to:

  - A welcome letter highlighting major program features, details that a card specific to the CCN will be sent via mail separately and contact information for the CCN;

  - The CCN Member ID Card;

  - A Member Handbook;, and

  - A Provider Directory (also must be available in searchable format on-line).

- The CCN shall adhere to the requirements for the Member Handbook, ID card, and Provider Directory as specified in this RFP, and in accordance with 42 CFR §438.10 (f)(6).

11.13.2. Welcome Calls

- The CCN shall make welcome calls to new members within fourteen (14) business days of receipt of the enrollment file from DHH or the Enrollment Broker identifying the new enrollee. During the phase-in implementation of the CCN program, the CCN may have up to twenty-one (21) days to make welcome calls.

- The CCN shall develop and submit to DHH for approval a script to be used during the welcome call to discuss the following information with the member:

  - A brief explanation of the program;
  - Statement of confidentiality;
  - The availability of oral interpretation and written translation services and how to obtain them free of charge;
  - The concept of the patient-centered medical home, including the importance of the member(s) making a

first appointment with his or her PCP for preventive care before the member requires care due to an illness or condition and instructions about changing PCPs; and

- A discussion to discover whether the member is pregnant has a chronic condition, or any special health care needs. Assistance in making an appointment with the PCP shall be offered to all members with such issues.

- The CCN shall make three (3) attempts to contact the member. If the CCN discovers that the member lost or never received the welcome packet, the CCN shall resend the packet.

- The CCN shall report to DHH on a monthly basis the name, telephone number and Medicaid Recipient ID Number of each member it attempted to contact after three attempts and were unable to successfully make contact.

11.14. <u>CCN Member Handbook</u>

11.14.1. The CCN shall develop and maintain a member handbook that adheres to the requirements in 42 CFR §438.10 (f)(6), in accordance with requirements as specified by DHH.

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

- Table of contents;

- A general description about how CCNs operate, member rights and responsibilities, appropriate utilization of services including Emergency Room for non-emergent conditions, a description of the PCP selection process, and the PCP's role as coordinator of services;

- Member's right to disenroll from CCN;

- Member's right to change providers within the CCN;

- Any restrictions on the member's freedom of choice among CCN providers;

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

- The amount, duration, and scope of benefits available to the member under the Contract between the CCN and DHH in sufficient detail to ensure that members understand the benefits to which they are entitled and information about health education and promotion programs, including chronic care management;

- Procedures for obtaining benefits, including prior authorization requirements;

- Description on the purpose of the Medicaid card and the CCN card and why both are necessary and how to use them;

- The extent to which, and how, members may obtain benefits, including family planning services and specialized behavioral health services from out-of-network providers;

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

    - What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR §438.114(a);

    - That prior authorization is not required for emergency services;

    - The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent;

    - The mechanism, incorporated in the member grievance procedures, by which a member may submit, whether oral or in writing, a service authorization request for the provision of services;

    - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered by the CCN; and

- That, subject to the provisions of 42 CFR §438, the member has a right to use any hospital or other setting for emergency care;

- The post-stabilization care services rules set forth in 42 CFR 422.113(c);

- Policy on referrals for specialty care, including specialized behavioral health services and for other benefits not furnished by the member's PCP;

- How and where to access any benefits that are available under the Louisiana Medicaid State Plan but, are not covered under the CCN's Contract with DHH, including pharmacy cost sharing for certain adults;

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

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

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

- Grievance, appeal and fair hearing procedures that include the following:

  - For State fair hearing:

    - The right to a hearing;

    - The method for obtaining a hearing; and

    - The rules that govern representation at the hearing.

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

- Information to call the Medicaid Customer Service Unit toll free hotline or visit a local Medicaid eligibility office to report if family size, living arrangements, parish of residence, or mailing address changes;
- How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";
- A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;
- How to obtain emergency and non-emergency medical transportation;

- Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;

- Information about the requirement that a member shall notify the CCN immediately if he or she has a Workman's Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in a auto accident;

- Reporting requirements for the member that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported to the CCN;

- Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the CCN or DHH. This shall include a statement that the member is responsible for protecting their ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;

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

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

- Any additional text provided to the CCN by DHH or deemed essential by the CCN;

- The date of the last revision;

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

    - Information on the structure and operation of the CCN;
    - Physician incentive plans [42 CFR 438.6(h)].
    - Service utilization policies; and

- How to report alleged marketing violations to DHH utilizing the Marketing Complaint Form. (See Appendix R of this RFP).

11.15. Member Identification (ID) Cards

11.15.1. CCN members will receive two (2) member identification cards.

11.15.1.1. A DHH issued ID card to all Medicaid eligibles, including CCN members. This card is not proof of eligibility, but can be used for accessing the state's electronic eligibility verification systems by CCN providers. These systems will contain the most current information available to DHH, including specific information regarding CCN enrollment. There will be no CCN specific information printed on the card. The CCN member will need to show this card to access Medicaid services not included in the CCN core benefits and services.

- A CCN issued member ID card that contains information specific to the CCN. The members ID card shall at a minimum include, but not be limited to the following:
  - The member's name and date of birth;
  - The CCN's name and address;
  - Instructions for emergencies;
  - The PCP's name, address and telephone numbers (including after-hours number, if different from business hours number);and
  - The toll-free number(s) for:
    - 24-hour Member Services and Filing Grievances
    - Provider Services and Prior Authorization and

- Reporting Medicaid Fraud (1-800-488-2917)

11.15.2. The CCN shall issue the CCN member ID card with the welcome packet. As part of the care mailing, the CCN must explain the purpose of the card, how to use the card, and how to use it in tandem with the DHH-issued card.

11.15.3. The card will be issued without the PCP information if no PCP selection has been made on the date of the mailing.

11.15.4. Once PCP selection has been made by the member or through auto assignment, the CCN will reissue the card in keeping with the time guidelines of this RFP and the Contract. As part of the mailing of the reissued card, the CCN must explain the purpose of the reissued card, the changes between the new card and the previous card, and what the enrollee should do with the previous car

11.15.5. The CCN shall reissue the CCN ID card within ten (10) calendar days of notice that a member reports a lost card, there is a member name change or the PCP changes, or for any other reason that results in a change to the information on the member ID card.

11.15.6. The holder of the member identification card issued by the CCN shall be a CCN member or guardian of a member. If the CCN has knowledge of any CCN member permitting the use of this identification card by any other person, the CCN shall immediately report this violation to the Medicaid Fraud Hotline number 1-800-488-2917.

11.15.7. The CCN shall ensure that its subcontractors can identify members in a manner which will not result in discrimination against the members, in order to provide or coordinate the provision of all **core** benefits and services and/or expanded services and out of network services.

11.16. <u>Provider Directory for Members</u>

11.16.1. The CCN shall develop and maintain a Provider Directory in three four (4) formats:

- A hard copy directory for members and upon request, potential members;

- Web-based, searchable, online directory for members and the public;
- Hard copy, abbreviated version for the Enrollment Broker; and
- Electronic file of the directory for the Enrollment Broker.

11.16.2. DHH or its designee shall provide the file layout for the electronic directory to the CCN after approval of the Contract. The CCN shall submit templates of its provider directory to DHH within thirty (30) days from the date the Contract is signed by the CCN.

11.16.3. The hard copy directory for members shall be reprinted with updates at least annually. Inserts may be used to update the hard copy directories monthly for new members and to fulfill requests by potential members. The web-based online version shall be updated in real time, however no less than weekly. The abbreviated hard copy version for the Enrollment Broker will be distributed to the new Medicaid enrollees. Format for this version will be in the format specified by DHH. The electronic version shall be updated prior to each submission to DHH's Fiscal Intermediary and the Enrollment Broker. While daily updates are preferred, the CCN shall at a minimum submit no less than weekly.

11.16.4. Consistent with 42 CFR 438.10(f) (6), the Provider Directory shall include, but not be limited to:

- Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the Medicaid enrollee's service area, including identification of providers, PCPs, specialists, and hospitals at a minimum, that are not accepting new patients;
- Identification of primary care physicians, specialists, and hospitals PCP groups, clinic settings, FQHCs and RHCs in the service area;
- Identification of any restrictions on the enrollee's freedom of choice among network providers; and

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

11.16.5. To assist Medicaid potential enrollees in identifying participating providers for each CCN, the Enrollment Broker will maintain and update weekly an electronic provider directory that is accessible through the Internet and will make available, (by mail) paper provider directories which comply with the member education material requirements of this RFP.

11.17. <u>Member Call Center</u>

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

- Explanation of CCN policies and procedures;
- Prior authorizations;
- Access information;
- Information on PCPs or specialists;
- Referrals to participating specialists;
- Resolution of service and/or medical delivery problems; and
- Member grievances.

11.17.2. The toll-free number must be staffed between the hours of 7 a.m. and 7 p.m. Central Time, Monday through Friday, excluding State declared holidays. The toll-free line shall have an automated system available 24-hour a day, seven days a week. This automated system must include the capability of providing callers with operating instructions on what to do in case of an emergency, and the option to talk directly to a nurse or other clinician or leave a message, including instructions on how to leave a message and when that message will be returned. The CCN must ensure that the voice mailbox has adequate capacity to receive all messages and that member services staff return all calls by close of business the following business day.

11.17.3. The CCN shall have sufficient telephone lines to answer incoming calls. The CCN shall ensure sufficient staffing to meet performance standards listed in this RFP. DHH reserves the right to specify staffing ratio and/or other requirements, if performance standards

are not meet or it is determined that the call center staffing/processes are not sufficient to meet member needs as determined by DHH.

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

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

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

11.17.7. **<u>Automatic Call Distribution</u>**

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

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

11.17.7.2. Transfer calls to other telephone lines;

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

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

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

11.17.7.6. Measure the length of time callers are on hold;

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

11.17.7.8. Measure the average hours of use per day;

11.17.7.9. Assess the busiest times and days by number of calls;

11.17.7.10. Record calls to assess whether answered accurately;

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

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

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

11.17.7.14. Performance Standards

- Answer ninety five (95) percent of calls within thirty (30) seconds or an automatic call pickup system;

- No more than one percent (1%) of incoming calls receive a busy signal;
- Maintain an average hold time of three (3) minutes or less;
- Maintain abandoned rate of calls of not more than five (5) percent.

- The CCN must conduct ongoing quality assurance to ensure these standards are met.
- If DHH determines that it is necessary to conduct onsite monitoring of the CCN's member call center functions, the CCN is responsible for all reasonable costs incurred by DHH or its authorized Agent(s) relating to such monitoring.

11.18. Member's Rights and Responsibilities

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

11.18.1. Members Rights

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

11.18.2. Member Responsibilities

- The CCN shall encourage each member to be responsible for his own health care by becoming an informed and active participant in their care. Members have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, providing accurate medical and personal histories, and being present at scheduled appointments and reporting on treatment progress, such as notifying their health care

provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.

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

11.19. <u>Notice to Members of Provider Termination</u>

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

11.19.2. The CCN shall provide notice to a member, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within

ten (10) calendar days from the date the CCN becomes aware of such, if it is prior to the change occurring.

11.19.3. The requirement to provide notice prior to the dates of termination, shall be waived when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the GSA service area and fails to notify the CCN, or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately (same day) upon the CCN becoming aware of the circumstances.

11.20. Additional Member Educational Materials and Programs

The CCN shall prepare and distribute educational materials, including, but not limited to, the following:

11.20.1. Bulletins or newsletters distributed not less than two (2) times a year that provide information on preventive care, access to PCPs and other providers and other information that is helpful to members;

11.20.2. Literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by the CCN. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;

11.20.3. Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;

11.20.4. Materials focused on health promotion programs available to the members;

11.20.5. Communications detailing how members can take personal responsibility for their health and self management;

11.20.6. Materials that promote the availability of health education classes for members;

11.20.7. Materials that provide education for members, with, or at risk for, a specific disability or illness;

11.20.8. Materials that provide education to members, members' families and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities;

11.20.9. Notification to its members of their right to request and obtain the welcome packet at least once a year;

11.20.10. Notification to its members of any change that DHH defines as significant at least thirty (30) calendar days before the intended effective date; and

11.20.11. All materials distributed must comply with the relevant guidelines established by DHH for these materials and/or programs.

11.21. Oral and Material Interpretation Services

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

11.21.2. The CCN shall ensure that where at least five percent (5%) or more of the resident population of a parish and/or service area is non-English speaking and speaks a specific foreign language, that materials are made available, at no charge, in that specific language to assure a reasonable chance for all members to understand how to access the CCN and use services appropriately as specified in 42 CFR §438.10(c) (4) and (5).

11.22. Marketing Reporting and Monitoring

11.22.1. Reporting to DHH

11.22.1.1. The CCN must provide a monthly report in a format prescribed by DHH (See Appendix T) to demonstrate

the progression of the marketing and member education plan. The monthly report must be provided by the 10th day of the following month and include a listing of all completed marketing activities and distributed marketing materials.

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

11.22.2. Reporting Alleged Violations

11.22.2.1. To ensure the fair and consistent investigation of alleged violations, DHH has outlined the following reporting guidelines:

- Alleged marketing violations must be reported to DHH in writing utilizing the Marketing Complaint Form (See Appendix R).
- Upon written receipt of allegations, DHH will:
  - Acknowledge receipt, in writing, within five (5) business days from the date of receipt of the allegation.
  - Begin investigation within five (5) business days from receipt of the allegation and complete the investigation within thirty (30) calendar days. DHH may extend the time for investigation if there are extenuating circumstances.
  - Analyze the findings and take appropriate action (see §18, Sanctions, for additional details).
  - Notify the complainant after appropriate action has been taken.

11.22.3. Sanctions

DHH may impose sanctions against the CCN for marketing and member education violations as outlined in §18.

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12 MEMBER GRIEVANCES AND APPEALS

The CCN shall have a grievance system in place that includes a grievance process and access to a state fair hearing. The system shall comply with the requirements set forth in all federal and state laws and regulations, including 42 CFR §431.200 and 42 CFR §§438.400 through 438.424. The CCN shall have written policies and procedures describing the grievance system. The CCN shall provide the policies and procedures to the Department for approval within thirty (30) days after the Contract is signed by the CCN and prior to implementation of any proposed revisions.

The CCN shall have a staff member designated as the grievance system coordinator and any additional staff necessary to comply with the requirements of this section, including those related to timeliness.

The CCN shall dispose of the grievance and notify the member in writing of the resolution in a timely manner that is appropriate for the complexity of the grievance and the member's health condition. Most grievances should be resolved within ten (10) business days of receipt or sooner. All grievances shall be resolved within the time frames specified below. The CCN shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances in accordance with all applicable state and federal laws. All appeals received by the CCN must be logged and directly forwarded to the State Fair Hearing process.

12.1. Definitions

12.1.1. Action

A termination, suspension, or reduction (which includes denial of a service based on Federal Office of General Counsel interpretation of CFR 431) of Medicaid eligibility or covered services.

12.1.2. Appeal

A request for review of an action, as "action" as defined in this .

12.1.3. Grievance

An expression of dissatisfaction about any matter other than an action, as "action'" is defined in this section. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. The term is also used to refer to the overall system

that includes CCN level grievances and access to State Fair Hearing.

12.2. General Requirements

12.2.1. Grievance System

The CCN must have a system in place for members that include a grievance process, and access to the State Fair Hearing system.

12.2.2. Filing Requirements

12.2.2.1. Authority to File

12.2.2.1.1. A member or representative of their choice may file a grievance and may request a State Fair Hearing in response to an action.

12.2.2.1.2. A network provider may file a grievance or request a State Fair Hearing on behalf of a member in response to an action.

12.2.2.1.3. The CCN shall assure that no punitive action is taken against a provider who files a grievance on behalf of a member or supports a member's grievance.

12.2.2.2. Timing

The member must be allowed thirty (30) calendar days from the date on the CCN's notice of action to request a State Fair Hearing. Within the timeframe the member, or a representative or provider acting on their behalf, may request a State Fair Hearing.

12.2.2.3. Procedures

12.2.2.3.1. The member may file a grievance either orally or in writing with the CCN.

12.2.2.3.2. The member, or a representative or provider acting on behalf of the member, may file for a State Fair hearing with the designated state

entity either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed State Fair Hearing request.

12.3. Notice of Grievance and State Fair Hearing Procedures

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

12.4. Grievance Records and Reports

The CCN shall maintain a log of all grievances and requests for fair hearings that shall be available to the Department in electronic format upon request (See Appendix U).

The CCN log shall be specific to the members covered by this RFP; entries in the log shall not be intermingled with entries about members from the CCN's other lines of business. At a minimum, the log shall contain:

- The member's name and member ID number;
- The date of filing;
- A description of the issue;
- The date of resolution;
- A description of the resolution;
- Whether the grievance was determined valid; and
- The date of member notification.

A copy grievances log shall be retained for six (6) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six (6) year period,

the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular six (6) year period, whichever is later.

The CCN shall provide quarterly reports in electronic format to DHH by the fifth (5th) calendar day of the following end of the quarter, that include all grievances and, if reached, their resolutions. The reports covering the previous quarter (January-March, April-June, July-September and October-December), shall include information about any trends that have been identified and interventions that may have been implemented. These reports with PHI redacted will be made publicly available for inspection

12.5. Handling of Grievances

The grievance procedures shall be governed by the following requirements:

12.5.1. General Requirements

In handling grievances, the CCN must meet the following requirements:

12.5.1.1. The CCN shall give members reasonable assistance in completing grievance and other procedural steps, including, but not limited to, providing a toll-free telephone number, translation services, and a toll-free number with Telephone Typewriter (TTY)/Telecommunication Device for the Deaf (TDD) and interpreter capability.

12.5.1.2. Acknowledge receipt of each grievance.

12.5.2. Resolution and Notification

Basic Rule: The CCN must dispose of a grievance and provide notice, as expeditiously as the member's health condition requires, within the timeframes established in § 11.8.3.1 below.

12.5.2.1. Specific Timeframes

12.5.2.1.1. Standard Disposition of Grievances

- For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety (90) days from the day the CCN receives the grievance.

- Extension of Timeframes
- The CCN may extend the timeframes from § 11.10 of this section by up to fourteen (14) calendar days if:
- The member requests the extension; or
- The CCN shows (to the satisfaction of DHH, upon its request) that there is need for additional information and how the delay is in the member's interest.
- Requirements Following Extension
- If the CCN extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.

12.5.3. Requirements for State Fair Hearings

12.5.3.1. Availability

The member may request a State Fair Hearing within thirty (30) days from the date of the notice of action following the resolution of the grievance.

12.5.3.2. Parties

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

12.5.3.3. Concurrent Appeal Review

The CCN shall conduct an internal concurrent review for each appeal for which a State Fair Hearing is requested. The purpose of the Concurrent Appeal Review is to expedite the resolution of the appeal to the satisfaction of the member, if possible, prior to the State Fair Hearing. The CCN shall notify the State Fair Hearing designated entity of Concurrent Appeal reviews resulting in a resolution in favor of the member. The Concurrent Appeal Review shall not delay the CCN's submission of an appeal to the State Fair Hearing process and shall not delay the review of the appeal in the State Fair Hearing.

12.5.4. Special Requirements for State Fair Hearing

All State Fair Hearing by members or on their behalf shall be filed with the state designated entity; however, if the CNN receives a State Fair Hearing request, the request shall be forwarded directly to the designated entity that will conduct the State Fair Hearing.

12.5.4.1. The CCN's staff shall be educated concerning the importance of the State Fair Hearing procedures and the rights of the member and providers.

12.5.4.2. The appropriate individual or body within the CCN that made the decision that is being brought to the State Fair Hearing shall be identified. This individual shall prepare the Summary of Evidence and be available for the State Fair Hearing either in person or by telephone.

12.6. Notice of Action

Notice of Action will only be sent by the CCN in certain circumstances as specified in this RFP.

12.6.1. Language and Format Requirements

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

12.6.2. Content of Notice

The notice must explain the following:

- The action the CCN or its contractor has taken or intends to take;
- The reasons for the action;
- The member's right to request a State Fair Hearing and a number to call for free Legal Advice;
- The procedures for exercising the rights specified in this section;
- The circumstances under which expedited resolution is available and how to request it; and
- The member's right to have benefits continues pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services.
- A statement in Spanish and Vietnamese that translation assistance is available at no cost and the toll free number to call to receive translation of the notice.

12.6.3. Timing of Notice

The CCN must mail the notice within the following timeframes:

12.6.3.1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 days before the date of action, except as permitted under 42 C.F.R. § 431.213 and 431.214.

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

- The member, or the provider, requests extension; or
- The CCN justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.

12.6.3.3. If the CCN extends the timeframe in accordance with § 11.9.3.2.1 or 11.9.3.2.2, it must:

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

12.6.3.4. On the date the timeframe for service authorization as specified in § 11.9.3.2 expires.

12.6.3.5. For expedited service authorization decisions where a provider indicates, or the CCN determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CCN must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no

later than seventy-two (72) hours after receipt of the request for service.

12.6.3.6. The CCN may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or provider acting on behalf of the member requests an extension, or if the CCN justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.

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

12.7. Continuation of Benefits While the State Fair Hearing Is Pending

12.7.1. Per 42 CFR § 431.230, if the enrollee requests a hearing before the date of action or within ten (10) days from the postmark of the notice, the agency may not terminate or reduce services until a decision is rendered after the hearing unless:

12.7.1.1. It is determined that the sole issue is one of Federal/state law or policy; and

12.7.1.2. The agency promptly informs the recipient in writing that services are to be terminated/reduced pending the hearing decision.

12.7.2. Member Responsibility for Services Furnished While the State Fair Hearing is Pending

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

12.8. Information about the Grievance System to Providers and Contractors

The CCN must provide the information about the grievance system to all providers and contractors at the time they enter into a contract as specified in this RFP.

12.9. Recordkeeping and Reporting Requirements

Reports of grievances and resolutions shall be submitted to DHH as specified in §16 of this RFP. The CCN shall not modify the grievance procedure without the prior written approval of DHH.

12.10. Effectuation of Reversed Decision Resolutions

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

12.11. Training of CCN Staff

The CCN's staff, including Member Services and Call Center staff, shall be educated concerning the importance of the grievance procedures and rights of the member and providers.

12.12. Reporting

The CCN, as part of its quality improvement process, shall track the grievances to identify trends. These trends shall be reported to the QAPI committee responsible for overall quality improvement for the CCN for identification of appropriate interventions if necessary.

12.13. Resolution Assistance

The CCN shall assist DHH in handling appeals of its members through the State Fair Hearing process. The CCN shall work with DHH toward simultaneous resolution of any appeals brought to their attention. The CCN shall not create barriers to timely due process. If determined by DHH that the CCN has created barriers to timely due process, the CCN shall be subject to sanctions for each incident and/or for each grievance.

12.14. Sanctions

The CCN shall be subject to sanctions if it is determined by the Department the CCN has created barriers to timely due process, and/or, if ten percent (10%) or higher of grievance decisions by the CCN have been overturned as a result of a State Fair Hearing decision within a twelve month period. Examples of creating barriers shall include but not be limited to:

- Binding arbitration clauses in CCN choice forms
- Failing to inform members of their due process rights
- Failing to log and process grievances
- Labeling complaints as inquiries and funneling them into an informal review
- Failure to issue a proper notice including vague or illegible notices
- Failure to inform of continuation of benefits
- Failure to inform of right to State Fair Hearing.

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13 SYSTEM AND TECHNICAL REQUIREMENTS

The CCN shall maintain an automated Management Information System (MIS), hereafter referred to as System, which accepts provider claims, verifies eligibility, validates prior authorization, pre-processes, and submits claims data to DHH's FI that complies with DHH and federal reporting requirements. The CCN shall ensure that its System meets the requirements of this RFP and all applicable state and federal laws, rules and regulations, including Medicaid confidentiality and HIPAA and American Recovery and Reinvestment Act (ARRA) privacy and security requirements.

The System shall have and maintain capacity sufficient to handle the workload projected for the begin date of operations and shall be scalable and flexible so that it can be adapted as needed, within DHH specified timeframes, in response to changes in the Contract requirements. The CCN shall provide service authorization for all services that require service authorization. The System shall have the capacity to pre-process all claims and submit claims for payment on a fee-for-service basis to the FI.

The CCN shall meet, as requested by DHH, with work groups or committees to coordinate activities and develop system strategies that actively reinforce the healthcare reform initiative.

The CCN shall submit pre-processed claims data to the FI in either an 837 electronic format or a paper claim, whichever was originally submitted by the billing provider.

Where deemed necessary by DHH, for the CCN's Web presence to be incorporated to any degree to DHH's web presence/portal; the CCN shall conform to all applicable state standards for website structure, coding, and presentation.

13.1. Data and Document Management Requirements

13.1.1. Adherence to Standards

The System shall conform and adhere to the data and document management standards of the FI including standard transaction code sets.

13.1.2. Confidentiality, Privacy, and Security

The CCN shall comply with all applicable state and federal confidentiality requirements, including, but not limited to, the

provisions of the HIPAA standards for data and document management, security, and privacy.

13.1.3. System Accessibility

The CCN's application systems foundation should employ the relational data model in its database architecture, which would entail the utilization of a relational database management system (RDBMS) such as Oracle®, DB2®, or SQL Server®. It is important that the application system support query access using Structured Query Language (SQL). Other standard connector technologies, such as Open Database Connectivity (ODBC) and/or Object Linking and Embedding (OLE), are desirable.

13.1.4. Data and Document Relationship

The System shall house indexed electronic images of documents to be used by members and providers to transact with the CCN and that are reposed in appropriate database(s) and document management systems (i.e., Master Patient Index) as to maintain the logical relationships to certain key data such as member identification, service authorization numbers, provider identification numbers and claim identification numbers. The CCN shall ensure that records associated with a common event, transaction or customer service issue have a common index that will facilitate search, retrieval and analysis of related activities, such as interactions with a particular member about a reported problem.

13.1.5. Retention

The CCN shall implement Optical Character Recognition (OCR) technology that minimizes manual indexing and automates the retrieval of scanned documents. The CCN shall provide DHH online retrieval and access to documents and files for six (6) years in live systems, for audit and reporting purposes, and ten (10) years in archival systems. Services which have a once in a life-time indicator (i.e., appendix removal, hysterectomy, etc.) are denoted on DHH's procedure formulary file and claims shall remain in the CCNs current/active claims history that is used in claims editing and are not to be archived or purged.

Online access to claims pre-processing data shall be by the Medicaid recipient ID, provider ID and/or ICN (internal control

number) to include pertinent claims data and claims status. The CCN shall provide forty-eight (48) hour turnaround or better on requests for access to information that is up to six (6) years old and seventy-two (72) hour turnaround or better on requests for access to information in machine readable form that is between six (6) to ten (10) years old. If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.

13.1.6. Information Ownership

All information, whether data or documentation, and reports that contain or reference information involving or arising out of this RFP is owned by DHH. The CCN is expressly prohibited from sharing or publishing DHH's information and reports without the prior written consent of DHH. In the event of a dispute regarding the sharing or publishing of information and reports, DHH's decision on this matter shall be final.

13.2. System and Data Integration Requirements

13.2.1. Adherence to Standards for Data Exchange

The System shall be able to transmit, receive, and process data in HIPAA-compliant or DHH specific formats and/or methods, including but not limited to, secure File Transfer Protocol (FTP) over a secure connection, such as a Virtual Provider Network (VPN), t during the on-site Readiness Review. Data elements and file format requirements may be found in ***the CCN-S Systems Companion Guide.*** The CCN shall maintain desktop workstation hardware and software compatible with current DHH standards as follows:

- Desktop Workstation Hardware:
  - IBM-compatible PC using at least a Dual Core Processor (2.66 GHz, 6 MB cache, 1333 MHz FSB);
  - At least 4 GB (gigabytes) of RAM;
  - At least 250 GB HDD;

- 256 MB discrete video memory;
- A color monitor or LCD capable of at least 800x640 screen resolution;
- A DVD +/-RW and CD-ROM drive capable of reading and writing to both media; and
- 1 gigabyte Ethernet card.

o Desktop Workstation Software:

- Operating system should be Microsoft Windows XP SP2 or later;
- Web browser that is equal to or surpasses Microsoft Internet Explorer v7.0 and is capable of resolving JavaScript and ActiveX scripts;
- An e-mail application that is compatible with Microsoft Outlook;
- An office productivity suite such as Microsoft Office that is compatible with Microsoft Office 2007 document standards;
- Each workstation should have access to the Internet;
- A desktop compression/encryption application that is compatible with WinZIP v11.0;
- Each workstation connected to the Internet should have anti-virus, anti-spam, and anti-malware software. Regular and frequent updates of the virus definitions and security parameters of these software applications should be established and administered; and
- All workstations, laptops and portable communication devices shall be installed with full disk encryption software.

The CCN shall comply with DHH's Electronic Claims Data Interchange (eCDI) annual certification of electronically submitted claims.

13.2.2. HIPAA Compliance

All HIPAA-conforming exchanges of data between DHH and the CCN are subject to the highest level of compliance as measured using an industry-standard HIPAA compliance checker. The Contract with the DHH is inclusive of the HIPAA Business Associate Agreement to this RFP (see Appendix C).

13.2.3. Connectivity and Interoperability

All applications, operating software, middleware, and networking hardware and software shall be interoperable with DHH's systems as needed and shall conform to applicable standards and specifications set forth by DHH. The System shall have the capability to transmit and receive claims data to and from the FI's system as required for the appropriate submission of claims data.

The CCN shall not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the CCN's span of control.

The CCN shall maintain computer hardware and software that provides the following established capabilities:

- Establish a local area network or networks as needed to connect all appropriate workstation personal desktop computers (PCs).
- Establish internet connection(s) so that all appropriate workstation PCs are able to access the Internet.
- Establish appropriate hardware firewalls, routers, and other security measures so that the CCN computer network is not able to be breached by an external entity.
- Establish appropriate back-up processes that ensure the back-up, archival, and ready retrieval of network server data and desktop workstation data.
- Ensure that network hardware is protected from electrical surges, power fluctuations, and power outages by using the appropriate uninterruptible power system (UPS) and surge protection devices.
- The CCN shall establish independent generator back-up power capable of supplying necessary power for four (4) days.

If a system update or change is necessary, the CCN shall draft appropriate revisions for the documentation or manuals for DHH review and approval and submit to DHH thirty (30) days prior to implementation of the revision. Documentation revisions shall be accomplished electronically and shall be made available for DHH review in an easily accessible, near real-time method. Printed manual revisions shall occur within ten (10) business days of the actual revision.

The Medicaid Management Information System (MMIS) processes claims and payments for covered Medicaid services. DHH's current MMIS contract expires December 31, 2010. DHH may exercise its right to extend all or part of a five (5) year extension to its current FI. DHH shall require the CCN to comply with transitional requirements as necessary, at no cost to DHH or its FI, should DHH contract with a new FI during the Contract.

13.2.4. Program Integrity (Fraud and Abuse)

The System shall be capable of generating files in prescribed formats for uploading to the FI's system that is used specifically for program integrity and compliance purposes. The CCN shall allow DHH personnel, agents of the Louisiana Attorney General's Office or individuals authorized by DHH or the Louisiana Attorney General's Office direct access to its system(s).

13.3. <u>Pre-Processed Claims Data Submission</u>

The System is required to conform to current HIPAA standard code sets.

The CCN shall submit all pre-processed clean claims data to the FI via standard transaction formats within two (2) business days of receipt of the clean claim from the provider. Information required which supports claims data reporting and submission is defined in the ***CCN-S Systems Companion Guide***.

13.3.1. The System shall, at a minimum, be capable of meeting the requirements listed below:

13.3.1.1. All claims shall be submitted either on paper or electronically in the standard HIPAA transaction formats, specifically the ANSI X12N 837 Transaction formats (P - Professional, and I - Institutional), and depending upon how the original claim was

submitted to the CCN. Compliance with all applicable HIPAA, federal and state mandates, both current and future is required.

13.3.1.2. The CCN shall have the ability to update CPT/HCPCS, ICD-9-CM, and other codes based on HIPAA standards and move to future versions as required.

13.3.1.3. In addition to CPT, ICD-9-CM and other national coding standards, the use of applicable HCPCS Level II and CPT Category II codes are mandatory, aiding the CCN and DHH to measure quality performance.

13.3.1.4. The CCN shall provide the FI with complete and accurate claims data for all levels of healthcare services.

13.3.2. MMIS identifies valid and invalid claims from a batch submission by the CCN. Any submission, which contains fatal transaction format errors that prevent processing, or that does not satisfy defined threshold error rates, will be rejected and returned to the CCN for immediate correction.

13.3.3. The CCN shall utilize DHH provider billing manuals and become familiar with the claims data elements that must be included in claims submissions. Due to the need for timely filing of data and to maintain integrity of processing sequence, the CCN shall address any issues that prevent processing of a claim.

13.4. <u>Eligibility and Enrollment Data Exchange</u>

13.4.1. The CCN shall:

13.4.1.1. Receive, process and update enrollment files sent daily by the Enrollment Broker;

13.4.1.2. Update its eligibility and enrollment databases within twenty-four (24) hours of receipt of said files;

13.4.1.3. Transmit to DHH, in the formats and methods specified in the HIPAA guide or as otherwise

specified by DHH, member address changes, telephone number changes;

13.4.1.4. Be capable of uniquely identifying (i.e., Master Patient Index) a distinct Medicaid member across multiple populations and Systems within its span of control; and

13.4.1.5. Be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by DHH, resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

13.5. Provider File

At the onset of this Contract and periodically as changes are necessary, DHH shall publish a Medicaid provider list at www.lamedicaid.com which includes provider types, specialty, and sub-specialty codes. The CCN shall utilize these codes within their provider file record. The objective is to coordinate the provider file records of the CCN with the same provider type, specialty and sub-specialty codes as those used by DHH and the Enrollment Broker.

13.5.1. The CCN shall:

13.5.1.1. Have the ability to electronically receive, process and update the provider information within their network in a database so that the Enrollment Broker is able to electronically access and identify available PCPs for member linkage.

13.5.1.2. Have the ability to create an electronic data file containing information on all Medicaid providers for service authorization and analysis purposes.

13.5.2. Provider file should include, at a minimum, the following functionality:

13.5.2.1. Linkages of individual providers to groups;

13.5.2.2. Provider office hours;

13.5.2.3. PCP capacity; and

13.5.2.4. Provider languages spoken.

13.6. System, Information Security and Access Management

13.6.1. The System shall:

13.6.1.1. Employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

13.6.1.1.1. Restrict access to information on a "least privilege" basis, such as users permitted inquiry privileges only, will not be permitted to modify information;

13.6.1.1.2. Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions shall be restricted to specified staff jointly agreed to by DHH and the CCN; and

13.6.1.1.3. Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.

13.6.1.2. Make System information available to duly authorized representatives of DHH and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

13.6.1.3. Contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to

be developed jointly by and mutually agreed upon by the CCN and DHH.

13.6.1.4. Ensure that audit trails be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:

13.6.1.4.1. Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

13.6.1.4.2. Have the date and identification "stamp" displayed on any on-line inquiry;

13.6.1.4.3. Have the ability to trace data from the final place of recording back to its source data file and/or document;

13.6.1.4.4. Be supported by listings, transaction reports, update reports, transaction logs, or error logs;

13.6.1.4.5. Facilitate auditing of individual records as well as batch audits; and

13.6.1.4.6. Be maintained online for no less than six (6) years; additional history shall be retained for no less than ten (10) years and shall be provide forty-eight (48) hour turnaround or better on request for access to information in machine readable form, that is between six (6) to ten (10) years old.

13.6.1.5. Have inherent functionality that prevents the alteration of finalized records;

13.6.1.6. Provide for the physical safeguarding of its data processing facilities and the systems and information

housed therein. The CCN shall provide DHH with access to data facilities upon request. The physical security provisions shall be in effect for the life of the Contract;

13.6.1.7. Restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access;

13.6.1.8. Include physical security features designed to safeguard processor sites through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel;

13.6.1.9. Put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of a CCN and or its contractor's span of control. This includes, but is not limited to, any provider or member service applications shall be directly accessible over the Internet and shall be appropriately isolated to ensure appropriate access;

13.6.1.10. Ensure that remote access users of its System can only access said System through two-factor user authentication such as Virtual Private Network (VPN), which must be prior approved by DHH during the on-site Readiness Review; and

13.6.1.11. Comply with recognized industry standards governing security of state and federal automated data processing systems and information processing. At a minimum, the CCN shall conduct a security risk assessment and communicate the results in an information security plan provided the on-site Readiness Review. The risk assessment shall also be available to appropriate federal agencies.

13.7. System Availability

13.7.1. The CCN shall:

13.7.1.1. Ensure that critical member and provider Internet and/or telephone-based IVR functions and information functions are available to the applicable System users twenty-four (24) hours a day, seven (7) days a week except during periods of scheduled System unavailability agreed upon by DHH and the CCN. Unavailability caused by events outside of the CCN's span of control is outside of the scope of this requirement;

13.7.1.2. Ensure that at a minimum all other System functions and information are available to the applicable system users between the hours of 7a.m. and 7p.m., Central Time, Monday through Friday;

13.7.1.3. Ensure that the systems and processes within its span of control associated with its data exchanges with the FI and/or Enrollment Broker are available and operational;

13.7.1.4. Ensure that in the event of a declared major failure or disaster, the CCN core eligibility/enrollment and claims processing systems shall be back on line within seventy-two (72) hours of the failure or disaster occurrence;

13.7.1.5. The CCN shall notify applicable DHH staff via phone, fax and/or electronic mail within sixty (60) minutes upon discovery of a problem within or outside of the CCN's span of control that may jeopardize or is jeopardizing availability and performance of critical systems functions and the availability of critical information as defined in this Section, including any problems impacting scheduled exchanges of data between the CCN and DHH. In its notification, the CCN shall explain in detail the impact to critical path processes such as enrollment management and claims submission processes;

13.7.1.6. The CCN shall notify applicable DHH staff via phone, fax, and/or electronic mail within fifteen (15) minutes upon discovery of a problem that results in delays in report distribution or problems in on-line access to critical systems functions and information during a business day, in order for the applicable work activities to be rescheduled or handled based on System unavailability protocol;

13.7.1.7. Provide information on System unavailability events, as well as status updates on problem resolution, to appropriate DHH staff. At a minimum these updates shall be provided on an hourly basis and made available via phone and/or electronic mail;

13.7.1.8. Resolve and implement system restoration within sixty (60) minutes of official declaration of unscheduled System unavailability of critical functions caused by the failure of system and telecommunications technologies within the CCN's span of control. Unscheduled System unavailability to all other System functions caused by system and telecommunications technologies within the CCN's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of System unavailability;

13.7.1.9. Cumulative System unavailability caused by systems and/or IS infrastructure technologies within the CCN's span of control shall not exceed twelve (12) hours during any continuous twenty (20) business day period;

13.7.1.10. Within five (5) business days of the occurrence of a problem with system availability, the CCN shall provide DHH with full written documentation that includes a corrective action plan describing how the CCN will prevent the problem from reoccurring; and

13.7.1.11. Not be responsible for the availability and performance of systems and IS infrastructure technologies outside of the CCN's span of control.

13.8. Contingency Plan

The CCN, regardless of the architecture of its System, shall develop and be continually ready to invoke a contingency plan to protect the availability, integrity, and security of data during unexpected failures or disasters, (either natural or man-made) to continue essential application or system functions during or immediately following failures or disasters.

Contingency plans include a disaster recovery plan (DRP) and a business continuity plan (BCP). A DRP is designed to recover systems, networks, workstations, applications, etc. in the event of a disaster. A BCP shall focus on restoring the operational function of the organization in the event of a disaster and includes items related to IT, as well as operational items such as employee notification processes and the procurement of office supplies needed to do business in the emergency mode operation environment. The practice of including both the DRP and the BCP in the contingency planning process is a best practice.

13.8.1. The CCN shall have a Contingency Plan that will be reviewed and approved by DHH during the Readiness Review. Minimum requirements of the Contingency Plan are defined below.

13.8.1.1. At a minimum, the Contingency Plan shall address the following scenarios:

- The central computer installation and resident software are destroyed or damaged;
- The system interruption or failure resulting from network, operating hardware, software, or operations errors that compromise the integrity of transaction that are active in a live system at the time of the outage;
- System interruption or failure resulting from network, operating hardware, software or operations errors that compromise the integrity of data maintained in a live or archival system;
- System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system, but does prevent

access to the System, such as it causes unscheduled System unavailability; and

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

13.8.2. The CCN shall annually test its plan through simulated disasters and lower level failures in order to demonstrate to DHH that it can restore System functions.

13.8.3. In the event the CCN fails to demonstrate through these tests that it can restore System functions, the CCN shall be required to submit a corrective action plan to DHH describing how the failure shall be resolved within ten (10) business days of the conclusion of the test.

13.9. Off Site Storage and Remote Back-up

13.9.1. The CCN shall provide for off-site storage and a remote back-up of operating instructions, procedures, reference files, system documentation, and operational files.

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

13.9.2.1. Descriptions of the controls for back-up processing, including how frequently back-ups occur;

13.9.2.2. Documented back-up procedures;

13.9.2.3. The location of data that has been backed up (off-site and on-site, as applicable);

13.9.2.4. The policies and procedures of such off-site location including compliance with HIPAA security rules;

13.9.2.5. The contractor must agree to produce, at its expense, legible hard copy records upon the request of state or federal authorities, within fifteen (15) calendar days of the request;

13.9.2.6. Identification and description of what is being backed up as part of the back-up plan; and

13.9.2.7. Any change in back-up procedures in relation to the CCN technology changes.

13.9.3. DHH shall be provided with a quarterly list of all back-up files stored at remote locations and the frequency with which these files are updated.

13.10. System User and Technical Support Requirements

13.10.1. The CCN shall provide Systems Help Desk services to Providers, DHH, the FI, and Enrollment Broker staff that have direct access to the CCN System.

13.10.2. The Systems Help Desk shall:

13.10.2.1. Be available via local and toll-free telephone service, and via e-mail from 7a.m. to 7p.m., Central Time, Monday through Friday, with the exception of DHH designated holidays. Upon request by DHH, the CCN shall be required to staff the Systems Help Desk on a state holiday, Saturday, or Sunday;

13.10.2.2. Answer questions regarding the CCN System functions and capabilities; report recurring programmatic and operation problems to appropriate staff for follow-up; redirect problems or queries that are not supported by the Systems Help Desk, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate DHH staff;

13.10.2.3. Ensure individuals who place calls after hours are able to leave a message. The CCN staff shall respond to messages left between the fours of 7:00 p.m. and 7:00 a.m. by noon the next business day;

13.10.2.4. Ensure recurring problems not specific to System unavailability identified by the System Help Desk shall be documented and reported to CCN management within one (1) business day of

recognition so that deficiencies are promptly corrected; and

13.10.2.5. Have an IS service management system that provides an automated method to record, track and report all questions and/or problems reported to the Systems Help Desk.

13.11. <u>System Testing and Change Management Requirements</u>

13.11.1. The CCN shall notify DHH staff of the following changes to System within its span of control within at least ninety (90) calendar days of the projected date of the change:

13.11.1.1. Major changes, upgrades, modification, conversions or updates to application or operating software associated with the following core production System:

- Claims pre-processing;
- Medicaid recipient eligibility verification processing;
- Service authorization management; and
- Provider file and data management.

13.11.1.2. The CCN shall respond to DHH notification of System problems not resulting in System unavailability according to the following timeframes:

- Within five (5) calendar days of receiving notification from DHH, the CCN shall respond in writing to notices of system problems.
- Within fifteen (15) calendar days, the correction shall be made or a requirements analysis and specifications document will be due.
- The CCN shall correct the deficiency by an effective date to be determined by DHH.

- The CCN System shall have a system-inherent mechanism for recording any change to a software module or subsystem.
- The CCN shall put in place procedures and measures for safeguarding against unauthorized modification to the CCN System.

13.11.1.3. Valid Timeframe for System Changes

Unless otherwise agreed to in advance by DHH as part of the activities described above, the CCN shall not schedule System unavailability to perform system maintenance, repair and/or upgrade activities to take place during hours that can compromise or prevent critical business operations.

13.11.1.4. Testing

The CCN shall work with DHH pertaining to any testing initiative as required by DHH and shall provide sufficient system access to allow testing by DHH and/or its FI of the CCN System during the on-site Readiness Review.

13.12. <u>Information Systems Documentation Requirements</u>

13.12.1. The CCN shall:

13.12.1.1. Ensure that written System process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems;

13.12.1.2. Develop, prepare, publish/print, maintain, produce, and distribute to DHH distinct System design and management manuals, user manuals and quick reference guides, and any updates;

13.12.1.3. Ensure the System user manuals contain information about, and instruction for, using applicable System functions and accessing applicable system data;

13.12.1.4. Ensure when a System change is subject to DHH prior written approval, the CCN and or its contractor will submit revision to the appropriate manuals before implementing said System changes;

13.12.1.5. Ensure all aforementioned manuals and reference guides be available in printed form and/or on-line; and

13.12.1.6. Update the electronic version of these manuals immediately, and updates to printed versions will occur within ten (10) business days of the update taking effect.

13.13. System Function Reporting Requirements

The CCN shall provide systems-based capabilities, such as ad-hoc tools, that enable designated DHH, FI or other DHH authorized staff or contractors, and designated Louisiana Attorney General Office staff, on a secure and read-only basis, query access to data that can be used in ad hoc reports.

13.14. Electronic Messaging

The CCN shall provide a continuously available electronic mail communication link (e-mail system) to facilitate communication with DHH. This e-mail system shall be capable of attaching and sending documents created using software compatible with DHH's installed version of Microsoft Office and any subsequent upgrades as adopted. As needed, the CCN shall be able to communicate with DHH over a secure VPN. The CCN shall comply with national standards for submitting protected public health information (PHI) electronically and shall set up a secure emailing system that is password protected for both sending and receiving any personal health information.

13.15. Address Standardization

The CCN System shall utilize mailing address standards in accordance with the United States Postal Service.

13.16. Electronic Medical Records

At such time that DHH requires, the CCN shall participate and cooperate with DHH to implement, within a reasonable timeframe, a secure, web-

accessible health record for members, such as Personal Health Record (PHR) or Electronic Health Records (EHR).

13.17. Statewide Health Information Exchange

At such time that DHH requires, the CCN shall participate in statewide efforts to incorporate all hospital, physician, and other provider information into a statewide health information exchange.

13.18. HIPAA-Based Formatting Standards

The System shall conform to the following HIPAA-compliant standards for information exchange. Batch transaction types include, but are not limited to, the following:

- ASC X12N 834 Benefit Enrollment and Maintenance;
- ASC X12N 835 Claims Payment Remittance Advice Transaction;
- ASC X12N 837I Institutional Claim/Encounter Transaction;
- ASC X12N 837P Professional Claim/Encounter Transaction;
- ASC X12N 278 Utilization Review Inquiry and Response; and
- ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products.

Transaction types are subject to change and the CCN shall comply with applicable federal and HIPAA standards and regulations as they occur.

13.19. Audit Requirements

The CCN shall ensure that their System facilitates the auditing of individual claims. Adequate audit trails shall be provided throughout the System. To facilitate claims auditing, the CCN shall ensure that the System follows, at a minimum, the guidelines and objectives of the American Institute of Certified Public Accountants (AICPA) Audit and Account Guide, *The Auditor's Study and Evaluation of Internal Control in EDP Systems.*

The CCN shall maintain and adhere to an internal EDP Policy and Procedures manual, available for DHH review upon request, which at a minimum shall contain and assure all accessible screens used throughout

the system adhere to the same Graphical User Interface (GUI) standards, and that all programmers shall adhere to the highest industry standards for coding, testing, executing and documenting all system activities. The manual is subject to yearly audit, by both state and independent auditors.

13.19.1. State Audit

The CCN shall provide to state auditors (including legislative auditors), upon written request, files for any specified accounting period that a valid Contract exists in a file format or audit defined media, magnetic tapes, CD or other media compatible with DHH and/or state auditor's facilities. The CCN shall provide information necessary to assist the state auditor in processing or utilizing the files.

If the auditor's findings point to discrepancies or errors, the CCN shall provide a written corrective action plan to DHH within ten (10) business days of receipt of the audit report.

At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the state auditors. These findings shall be reviewed by DHH and integrated into the CCN's EDP manual.

13.19.2. Independent Audit

13.19.2.1. The CCN shall be required to subcontract with an independent firm, subject to the written approval of DHH, which has experience in conducting EDP and compliance audits in accordance with applicable federal and state auditing standards for applications comparable with the scope of the Contract's System application. The independent firm shall:

- Perform limited scope EDP audits on an ongoing and annual basis using DHH's audit program specifications at the conclusion of the first twelve (12) month operation period and each twelve (12) month period thereafter, while the Contract is in force with DHH and at the conclusion of the Contract; and

- o Perform a comprehensive audit on an annual basis to determine the CCN's compliance with the obligations specified in this RFP.

13.19.2.2. The auditing firm shall deliver to the CCN and to DHH a report of findings and recommendations within thirty (30) calendar days of the close of each audit. The report shall be prepared in accordance with generally accepted auditing standards for EDP application reviews.

13.19.2.3. DHH shall use the findings and recommendations of each report as part of its monitoring process.

13.19.2.4. The CCN shall deliver to DHH a corrective action plan to address deficiencies identified during the audit within ten (10) business days of receipt of the audit report. At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the independent auditing firm. These findings are reviewed by DHH and shall become a part of the CCN's EDP manual.

13.19.2.5. Audits shall include a scope necessary to fully comply with AICPA Professional Standards for Reporting on the Processing of Transactions by Service Organizations (SAS-70 Report).

13.20. <u>Systems Refresh Plan</u>

The CCN shall provide to DHH an annual System Refresh Plan. The plan shall outline how Systems within the CCN's span of control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors.

The systems refresh plan shall also indicate how the CCN will insure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM),

software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the System component.

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14 CLAIMS MANAGEMENT

14.1. General Provisions

In accordance with the requirements set forth in this RFP, the CCN shall notify providers to file all claims directly to the CCN for services provided to CCN members. Claims submitted directly to DHH's FI for a CCN member will be denied.

It is the CCN's responsibility to inform and educate all providers involved in the provision of care, to adhere to the CCN and DHH claims processing process. The CCN shall disseminate materials and maintain a record of all educational materials. The CCN must accept submission of claims from providers in either electronic or hard copy paper form.

The CCN shall specify the timeframe in which a provider has to submit a clean claim with the CCN. The CCN must accept and pre-process claims within two (2) business days of receipt. Preprocessed approved claims will be paid on a fee-for-service (FFS) basis by DHH. DHH shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or SCHIP program pursuant to Section 1128 or 1156 of the Social Security Act or is otherwise not in good standing with DHH.

14.2. CCN Responsibilities-Service Authorization

14.2.1. The CCN shall maintain a claims management System that will:

14.2.1.1. Provide service authorization approval to providers utilizing a unique authorization number as defined in the ***CCN-S Systems Companion Guide***;

14.2.1.2. Confirm CCN membership as service authorization requests are submitted on the basis of the eligibility information provided by DHH;

14.2.1.3. Verify medical necessity as defined by DHH;

14.2.1.4. Identify date of receipt (the date the CCN receives the claim);

14.2.1.5. Provide on-line and phone based capabilities to providers for obtaining status information;

14.2.1.6. Obtain a submitter identification number from the FI prior to submitting claims;

14.2.1.7. Submit electronic claims received from providers to the FI within two (2) business days of receipt;

14.2.1.8. Submit paper claims to the FI in batch form within two (2) business days of receipt. The FI maintains claims billing information on the DHH Medicaid website: http://www.lamedicaid.com/provweb1/billing_information; and

14.2.1.9. The following link will provide various address information for submitting paper claims: http://www.lmmis.com/provweb1/ProviderTraining/packets/2006ProviderTraning/0133%20%202006%20Basic%20Services%20Training.pdf

14.3. FI Responsibilities-Service Authorization

14.3.1. Ensure MMIS verifies that a service is a covered service and is eligible for payment;

14.3.2. Perform system edits for valid dates of service, and assure that dates of services are valid dates such as not in the future or outside of a members eligibility span;

14.3.3. Identify date of receipt; and

14.3.4. Provide web-based claims status and inquiry capability.

14.4. FI Responsibilities-Prompt Payment

14.4.1. The FI shall adhere to prompt payment requirements established under the American Recovery and Reinvestment Act of 2009. This ensures that ninety percent (90%) of clean

claims for payment of services delivered to a member are paid to the provider within thirty (30) calendar days of the receipt of such claims and process and if appropriate pay, within ninety (90) calendar days, ninety-nine percent (99%) of all provider claims for covered services delivered to a member. The thirty (30) calendar days starts the date of claims receipt by the FI. Therefore, it is extremely important that the CCN adhere to the two (2) business day rule established by DHH. Sanctions or monetary penalties may be applied to the CCN for non-compliance with this rule.

14.4.2. If a claim is partially or totally denied on the basis the provider did not submit required information or documentation with the claim, then a remittance advice or other appropriate written or electronic notice shall specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the timeframe for claims processing.

14.5. <u>Claim Formats</u>

14.5.1. The System as defined in § 13 of this RFP shall conform to HIPAA-compliant standards for information exchange. Transaction types are subject to change and the CCN shall comply with applicable federal and HIPAA standards and regulations as they occur.

14.5.2. The CCN shall require that providers comply at all times with standardized paper billing forms and formats, and all future updates for Professional claims (CMS 1500), Institutional claims (UB 04), and Louisiana's KM3 form for EPSDT/KidMed billing of paper claims. All electronic claims shall be submitted to DHH in the standard HIPAA transaction formats, specifically the ANSI X12N 837 Transaction formats (P - Professional, and I - Institutional). If service authorization was received, the unique authorization number must be submitted either on the paper claim or the electronic claim.

14.5.3. The CCN shall not revise or modify the standardized forms or formats.

14.5.4. The CCN shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with DHH. These shall include, but not be limited to, HIPAA based standards, federally required safeguard requirements including signature requirements described in the CMS State Medicaid Manual.

14.5.5. The CCN agrees that at such time that DHH presents recommendations concerning claims billing and processing that are consistent with industry norms, the CCN shall comply with said recommendations within ninety (90) calendar days from notice by DHH.

14.6. <u>Service Authorization Disputes</u>

14.6.1. The CCN shall:

14.6.1.1. Have an internal claims dispute procedure that will be reviewed and approved by DHH, within thirty (30) days after the Contract is signed by the CCN and upon any changes;

14.6.1.2. Create a peer-to-peer internal review process separate from the parties who made the original determination to review disputed authorizations;

14.6.1.3. Adhere to the appeals process outlined in §11 of the Contract; and

14.6.1.4. Systematically capture the status and resolution of all authorization disputes as well as all associated documentation.

14.6.2. For audit and verification purposes, the service authorization requests shall be maintained.

14.7. <u>Remittance Advices and Related Functions</u>

14.7.1. In conjunction with its payment cycles, the FI shall provide the CCN with:

14.7.1.1. An electronic status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment;

14.7.1.2. The status report shall contain appropriate explanatory remarks related to payment or denial of the claim;

14.7.1.3. Assist providers in reconciliation of claims; and

14.7.1.4. If the claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice shall specifically identify all such information and documentation.

14.8. Payment Cycles

The FI receives claims twenty-four (24) hours per day seven (7) days per week. Claims which are received on or before 10:00 a.m. each Thursday will be processed in that week's batch cycle, and the claim is adjudicated (paid/denied) on the subsequent Tuesday.

14.9. National Correct Coding Initiative

The CCN must comply with the requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), regarding "Mandatory State Use of National Correct Coding Initiatives," including all applicable rules, regulations, and methodologies implemented as a result of this initiative.

14.10. Self Audit Requirements

The CCN shall meet a ninety-nine percent (99%) submission rate of clean claims received forwarded and received by the FI within two (2) business days. Clean paper claims requiring attachments that are authorized at the time of adjudication are exempt from this standard. Clean paper claims requiring attachments shall be submitted within four (4) business days from receipt from the provider.

The CCN shall time and date stamp all claims when received by the provider, whether received in paper or in electronic 837 format. The CCN shall provide the Julian date of receipt and date of submission to the FI.

Pre-processed claims must be submitted to the FI no later than two (2) business days of receipt of a claim from a provider. The CCN Internal Control Number (ICN) should reflect the Julian date that the claim was pre-processed. Per the CCN-S Systems Companion Guide, the CCN ICN is to be populated in loop 2300, MEDICAL RECORD NUMBER, REF02, data element 127. A reference identification qualifier value of EA is to be used in REF01, data element 128.

Upon request by DHH, the CCN shall create an audit report demonstrating the percent of claims submitted to the FI within two business days from date received from the provider.

In addition, complaints should be tracked and a performance penalty can be imposed if complaints from providers reporting delayed payments for correctly submitted clean claims can be substantiated.

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15 FRAUD, ABUSE AND WASTE PREVENTION

15.1. General Requirements

15.1.1. The CCN shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP programs.

15.1.2. The CCN shall cooperate and assist the state and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. At any time during normal business hours, HHS, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, DHH, and/or any of the designees of the above, and as often as they may deem necessary during the Contract period and for a period of six (6) years from the expiration date of the Contract (including any extensions to the Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the Contract and any other applicable rules.

15.1.3. The CCN shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have the right to examine and make copies, excerpts or transcripts from all records, contact and conduct private interviews with CCN clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The CCN shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

15.1.4. The CCN shall provide access to DHH and/or its designee to all information related to grievances and appeals files by its members. DHH shall monitor enrollment and termination practices and ensure proper implementation of the CCN's grievance procedures, in compliance with 42 CFR §438.226-438.228 (2006, as amended).

15.1.5. The CCN shall certify all statements, reports and financial and otherwise, as true, accurate, and complete. The CCN shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, the Contract, and DHH policy.

15.1.6. The CCN will report to DHH, within three (3) business days, when it is discovered that any CCN employees, network provider, contractor, or contractor's employees have been excluded, suspended, or debarred from any state or federal healthcare benefit program.

15.2. <u>Prohibited Affiliations</u>

15.2.1. In accordance with 42CFR 438.610, the CCN is prohibited from knowingly having a relationship with:

15.2.1.1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the federal acquisition regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 The CCN shall comply with all applicable provisions of 42 CFR Part 376 (2009, as amended), pertaining to debarment and/or suspension. The CCN shall screen all employees and contractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the CCN shall search the following websites:

- Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) http://www.oig.hhs.gov/fraud/exclusions.aspx ;

- Health Care Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index ; and

- Excluded Parties List Serve (EPLS) http://www.epls.gov

15.2.2. The CCN shall conduct a search of these websites monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered should be immediately reported to DHH. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR §1003.102(a)(2).

15.2.3. An individual who is an affiliate of a person described above and include:

15.2.3.1. A director, officer, or partner of the CCN;

15.2.3.2. A person with beneficial ownership of 5 percent or more of the CCN's equity; or

15.2.3.3. A person with an employment, consulting or other arrangement with the CCN for the provision of items and services which are significant and material to the CCN's obligations.

15.2.4. The CCN shall notify DHH within three (3) days of the time it receives notice that action is being taken against the CCN or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or

any contractor which could result in exclusion, debarment, or suspension of the CCN or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

15.3. Reporting

15.3.1. In accordance with 42 CFR §455.1(a)(1) and §455.17, the CCN shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect information to the DHH's Medicaid Program Integrity Section within five (5) business days of discovery, taking prompt corrective actions and cooperating with DHH in its investigation of the matter(s). Additionally, the CCN shall notify DHH within three (3) business days of the time it receives notice that action is being taken against the CCN or CCN employee, network providers contractor or contractor employee or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the CCN or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

15.3.2. The CCN has an affirmative duty to provide a quarterly report all activities on a quarterly basis to DHH. If fraud, abuse, waste and neglect issues are suspected, the CCN shall report it to DHH immediately upon discovery. Reporting shall include, but are not limited to:

15.3.2.1. Number of complaints of fraud, abuse, waste, and neglect made to the CCN that warrant preliminary investigation; and

15.3.2.2. Number of complaints reported to the Compliance Officer.

15.3.2.3. For each complaint that warrants investigation, the CCN shall provide DHH, at a minimum, the following:

- Name and ID number;
- Source of complaint;

- Type of provider;
- Nature of complaint;
- Approximate dollars involved if applicable; and
- Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.

15.4. Medical Records

15.4.1. The CCN shall have a method to verify that services for which authorization for reimbursement was made, was provided to members. The CCN shall have policies and procedures to maintain, or require CCN providers and contractors to maintain, an individual medical record for each member. The CCN shall ensure the medical record is:

15.4.2. Accurate and legible;

15.4.3. Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all members evaluated or treated, and is accessible for review and audit; and

15.4.4. Readily available for review and provides medical and other clinical data required for Quality and Utilization Management review.

15.4.5. The CCN shall ensure the medical record includes, minimally, the following:

15.4.5.1. Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);

15.4.5.2. Primary language spoken by the member and any translation needs of the member;

15.4.5.3. Services provided through the CCN, date of service, service site, and name of service provider;

15.4.5.4. Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the CCN;

15.4.5.5. Referrals including follow-up and outcome of referrals;

15.4.5.6. Documentation of emergency and/or after-hours encounters and follow-up;

15.4.5.7. Signed and dated consent forms (as applicable);

15.4.5.8. Documentation of immunization status;

15.4.5.9. Documentation of advance directives, as appropriate;

15.4.5.10. Documentation of each visit must include:

- Date and begin and end times of service;
- Chief complaint or purpose of the visit;;
- Diagnoses or medical impression;
- Objective findings;
- Patient assessment findings;
- Studies ordered and results of those studies (e.g. laboratory, x-ray, EKG);
- Medications prescribed;
- Health education provided;
- Name and credentials of the provider rendering services (e.g. MD, DO, OD) and the signature or initials of the provider; and
- Initials of providers must be identified with correlating signatures.

15.4.6. Documentation of EPSDT requirements including but not limited to:

- Comprehensive health history;
- Developmental history;
- Unclothed physical exam;

- Vision, hearing and dental screening;
- Appropriate immunizations;
- Appropriate lab testing including mandatory lead screening; and
- Health education and anticipatory guidance.

15.4.7. The CCN is required to provide one (1) free copy of any part of member's record upon member's request.

15.4.8. an administrative or judicial action brought by or on behalf of the state or federal government.

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16 REPORTING REQUIREMENTS

16.1. The CNN is responsible for complying with all the reporting requirements established by DHH.

16.2. The CCN must have the capability to connect to DHH's FI using TCP/IP protocol on a specific port at no cost to DHH or its FI. Connectivity must be verified by DHH's FI to DHH in writing. The CCN shall provide DHH a sample of all reports within forty-five (45) days of the date the Contract is signed by the CCN. The requirements for electronic files submissions are specified in this RFP and CCN-S Systems Companion Guide.

16.3. The CCN shall create reports or files (known as Deliverables) using the formats, including electronic formats, instructions, and timeframes as specified by DHH and at no cost to DHH. Any changes to the format must be approved by DHH prior to implementation. The CCN shall provide to DHH and any of its designee's copies of reports generated by the CCN concerning CCN members and any additional reports requested by DHH or its designee in regard to performance of the Contract.

16.4. DHH will provide the CCN with the appropriate reporting formats, instructions, submission timetables, and technical assistance when required. All reports shall be submitted in accordance with the schedule outlined in this RFP. In the event that there are no instances to report, the CCN shall submit a reporting stating so.

16.5. The CCN shall certify all submitted data, documents and reports. The data that must be certified include, but are not limited to, enrollment information, financial reports, claims pre-processed and other information as specified within this RFP. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The CCN must submit the certification concurrently with the certified data and documents. DHH will identify specific data that requires certification.

16.5.1. The data shall be certified by one of the following:

(1) CCN's Chief Executive Officer (CEO);
(2) CCN's Chief Financial Officer (CFO); or
(3) An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO

16.6. Ad Hoc Reports

The CCN shall prepare and submit any other reports as required and requested by DHH, any of DHH designees, and/or CMS, that is related to the CCN's duties and obligations under this Contract. Information considered to be of a proprietary nature shall be clearly identified as such by the CCN at the time of submission. DHH will make every effort to provide a sixty (60) day notice of the need for submission to give the CCN adequate time to prepare the reports.

16.7. CCN-S's Network of Providers and Subcontractors

The CCN shall furnish to DHH and/or its designee a monthly report of all network providers and subcontractors enrolled in the CCN's network.

The CCN shall also furnish to DHH or its designee adequate copies of the PCP listing as requested by DHH. DHH will provide the CCN with Medicaid provider identification numbers.

It shall be the CCN's responsibility to assure confidentiality of the Medicaid Providers' identification number and indemnity of DHH in accordance with this RFP.

DHH is to be provided advance copies in electronic format of all updates in the network providers that include material changes not less than ten (10) business days in advance of distribution. Any provider no longer taking new patients must be clearly identified. Any enrollee age restrictions for a provider must be clearly identified.

16.8. Ownership Disclosure

Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR §455.100-455.104). Form CMS 1513, Ownership and Control Interest Statement, is to be submitted to DHH with its response to this RFP; then resubmitted prior to implementation for each Contract period or when any change in the CCN's management, ownership or control occurs. The CCN shall report any changes in ownership and disclosure information to DHH within thirty (30) calendar days prior to the effective date of the change.

16.9. Information Related to Business Transactions

The CCN shall furnish to DHH or to the U.S. Department of Health & Human Services (HHS) information upon request related to significant business transactions as set forth in 42 CFR § 455.105. Failure to comply with this requirement may result in termination of the Contract.

The CCN shall submit, within thirty-five (35) days of a request made by DHH, full and complete information about:

16.9.1. The ownership of any contractor with whom the CCN has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the 12-month period ending on the date of this request; and

16.9.2. Any significant business transactions between the CCN and any wholly owned supplier, or between the CCN and any contractor, during the five-year period ending on the date of this request.

16.9.3. For the purpose of this RFP, "significant business transactions" means any business transaction or series of transactions during any state fiscal year that exceed the twenty-five thousand dollar ($25,000) or 5% of the CCN's total operating expenses whichever is greater.

16.10. Information on Persons Convicted of Crimes

The CCN shall furnish DHH and HHS information related to any provider convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) and CHIP (Title XXI) as set forth in 42 CFR § 455.106. Failure to comply with this requirement may lead to termination of the Contract or disqualification of the RFP.

16.11. Errors

The CCN agrees to prepare complete and accurate reports for submission to DHH. If after preparation and submission, a CCN error is discovered either by the CCN or DHH; the CCN shall correct the error(s) and submit accurate reports as follows:

a. For all reports – Fifteen (15) calendar days from the date of discovery by the CCN or date of written notification by DHH

(whichever is earlier). DHH may at its discretion extend the due date if an acceptable corrective action plan has been submitted and the CCN can demonstrate to DHH's satisfaction the problem cannot be corrected within fifteen (15) calendar days.

16.12. Report Submission Timeframes

The CCN shall ensure that all required reports or files, as stated in this RFP, are submitted to DHH in a timely manner for review and approval. The CCNs failure to submit the reports or files as specified may result in the assessment of liquidated damages, as stated in the Administrative Actions, Monetary Penalties and Sanctions Section of this RFP.

16.12.1.1. Unless otherwise specified, deadlines for submitting files and reports are as follows:

16.12.2. Daily reports and files shall be submitted within one (1) business day following the due date;

16.12.3. Weekly reports and files shall be submitted on the Wednesday following the reporting week;

16.12.4. Monthly reports and files shall be submitted within fifteen (15) calendar days of the end of each month;

16.12.5. Quarterly reports and files shall be submitted by April 30, July 30, October 30, and January 30, for the quarter immediately preceding the due date;

16.12.6. Annual reports and files shall be submitted within thirty (30) calendar days following the twelfth (12th) month; and

16.12.7. Ad Hoc reports shall be submitted within three (3) business days from the agreed upon date of delivery.

Submitter	Report or File Name	Frequency	Format Location	Receiver
CCN	Organizational Chart	Annually	N/A	DHH – Coordinated Care Section

Submitter	Report or File Name	Frequency	Format Location	Receiver
CCN	Functional Organizational Chart	Annually	N/A	DHH – Coordinated Care Section
CCN	Network Provider and Subcontractor Spreadsheet and Registry	30 days after the Contract has been signed and Monthly thereafter	Appendix X and Systems Companion Guide	DHH – Coordinated Care Section
DHH	Readiness Review Report	As Appropriate	TBD	CCN
CCN	Patient-Center Medical Home (PCMH) A. PCMH Implementation Plan B. NCQA PCP-PCMH™ recognition report	30 days after the Contract has been signed and Annually thereafter	TBD	DHH – Coordinated Care Section
CCN	PCP Care Management Fee Report	Quarterly	Systems Companion Guide	DHH – Coordinated Care Section
DHH – FI	New Enrollee File	Daily	Systems Companion Guide	EB

Submitter	Report or File Name	Frequency	Format Location	Receiver
CCN	Provider Directory	Template due during Readiness Review	TBD	EB
EB	Provider Directory	Weekly	TBD	DHH
EB	Member Linkage File	Daily	Systems Companion Guide	CCN
EB	Member Linkage File	Daily	Systems Companion Guide	DHH – FI
CCN	PCP Linkage File	Quarterly	Systems Companion Guide	DHH - FI
CCN	Member Services A. Unsuccessful new member contacts B. Member services Call Center	A. Monthly B. Monthly with an Annual Summary	TBD	DHH – Coordinated Care Section
CCN	Provider Call Center	Monthly with an Annual Summary	TBD	DHH – Coordinated Care Section

Submitter	Report or File Name	Frequency	Format Location	Receiver
CCN	Referral Policies	30 days after the Contract has been signed, Annually thereafter, and prior to any revisions	TBD	DHH – Coordinated Care Section
EB	Member Disenrollment File	Daily	Systems Companion Guide	DHH – FI
EB	Member Disenrollment File	Daily	Systems Companion Guide	CCN
CCN	CCN Disenrollment Report	Quarterly	Appendix Y	DHH - Coordinated Care Section
DHH – FI	CCN PMPM Reconciliation File	Monthly	Systems Companion Guide	CCN
CCN	UM Reports A. UM Committee Meeting minutes B. Medical Record Reviews	A. Within 5 working days of each meeting B. Quarterly with an Annual Summary	TBE	DHH – Coordinated Care Section
CCN	CCMP A. Reports B. Predictive Modeling Specifications C. Program Evaluation	A. Quarterly with an Annual Summary B. Readiness review and Annually thereafter C. Annually	TBD	DHH – Coordinated Care Section

Submitter	Report or File Name	Frequency	Format Location	Receiver
CCN	Fraud and Abuse Activity Report	Quarterly with an Annual Summary	TBD	DHH – Coordinated Care Section
CCN	Model Attestation Letter	Attachment to all Reports	Appendix Z	DHH – Coordinated Care Section
CCN	Service Authorization Requests Report	Upon Request by DHH	TBD	DHH – Coordinated Care Section
CCN	Form CMS 1513 Ownership and Control Interest Statement	With proposal and annually, by October 1st, , thereafter	N/A	DHH – Coordinated Care Section
CCN	Emergency Management Plan	30 days prior to proposed changes, Annual certification	N/A	DHH – Coordinated Care Section
CCN	Member Satisfaction Survey Report	Annually	Instrument and Survey Results	DHH – Coordinated Care Section
CCN	Provider Satisfaction Survey Report	Annually	Instrument and Survey Results	DHH – Coordinated Care Section
CCN	Network Provider Development and Management Plan	30 days after the Contract has been signed and Annually thereafter	TBD	DHH – Coordinated Care Section

Submitter	Report or File Name	Frequency	Format Location	Receiver
CCN	Grievance, Appeal and Fair Hearing Log Report	Monthly, and Quarterly Summary	Appendix U	DHH – Coordinated Care Section
CCN	Grievance, Appeal and Fair Hearing Log - Redacted	Monthly, and Quarterly Summary	Appendix U	DHH – Coordinated Care Section
CCN	Marketing Activities A. Marketing Plan B. Updates C. Annual Review	A. 30 days after the Contract has been signed B. Monthly C. Annually	Appendix T (TBE)	DHH – Coordinated Care Section
CCN	Pre-processing Report	Daily	Systems Companion Guide	DHH – Coordinated Care Section
CCN	Financial Reporting	A. Annual Audited Financial Statement B. Four Quarterly Unaudited Financial Statements, and Financial Reporting Guide C. Monthly if requested by DHH	Financial Reporting Companion Guide	DHH – Coordinated Care Section
CCN	Quality Assurance (QA) A. QAPI Program description and QAPI Plan B. Impact and effectiveness of QAPI program evaluation	Annually thereafter A. 30 days from the date of the Contract and Annually thereafter B. Annually C. Within 3 months	Quality Companion Guide TBE	DHH – Coordinated Care Section

Submitter	Report or File Name	Frequency	Format Location	Receiver
	C. Performance Improvement Project descriptions D. Performance Improvement Projects Outcomes E. Early Warning System Performance Measures F. Level I and Level II Performance Measures G. PCP Profile Reports	of execution of the Contract and at the beginning of each Contract year thereafter D. Annually E. Monthly F. Annually and upon DHH request G. Quarterly with an Annual Summary		
CCN	System Refresh Plan	Annually	Systems Companion Guide	DHH - Coordinated Care Section
CCN	Back-up File List	Quarterly	Systems Companion Guide	DHH – Coordinated Care Section
CCN	Electronic Data Processing (EDP) Audit	Annually	TBD	DHH- Coordinated Care Section
DHH – FI	Claims Historical Data and Immunization Data	At onset of implementation and Monthly thereafter	Systems Companion Guide	CCN
DHH - FI	Claims Summary	Weekly	Systems Companion Guide	CCN

Submitter	Report or File Name	Frequency	Format Location	Receiver
DHH – FI	Claim Edit Disposition File	Weekly	Systems Companion Guide	CCN
DHH – FI	Claim Detail	Weekly	Systems Companion Guide	CCN
CCN	Case Management Reports	Quarterly with an Annual Summary	TBD	DHH – Coordinated Care Section
CCN	Prior Authorization and Pre-Certification Summary	Annually	Systems Companion Guide	DHH – Coordinated Care Section
CCN	Telephone and Internet Activity Report	Monthly	TBD	DHH- Coordinated Care Section
CCN	Member Advisory Council Plan	Annually with Quarterly updates of meeting minutes and correspondence	N/A	DHH – Coordinated Care Section

17 COMPLIANCE AND MONITORING

17.1. Required Submissions

Within thirty (30) calendar days from the date the Contract is signed by the CCN or as specified in this RFP, the CCN shall submit the required documents to DHH. DHH shall have the right to approve, disapprove or require modification of these documents and any procedures, policies and materials related to the CCN's responsibilities under the terms of the Contract. Refer to Appendix AA, Transition Period Requirements for a listing of submission requirements.

17.2. Readiness Review Prior to "Go Live" Date

DHH will assess the performance of the selected CCNs prior to and after the January 2012 "go live" date. DHH will complete readiness reviews of CCNs prior to implementation. Refer to Appendix AA for Transition Period Requirements. If the CCN does not pass the Readiness Review within the timeframe specified by the Schedule of Events, DHH will terminate the contract process with the CCN.

The purpose of the on-site review at the CCN's Louisiana location is to assess the capability and capacity of the CCN to meet the requirements set forth in this RFP, the Contract and department issued ***Guides***.

The CCN shall assist DHH to the fullest extent possible during this Readiness Review.

DHH will conduct on-site readiness reviews prior to member enrollment during initial implementation of the CCN Program and as an ongoing activity during the Contract period. The CCN's on-site review will include a desk audit and on-site focus component. The site review will focus on specific areas of CCN performance. These focus areas may include, but are not limited to the following:

- Administrative capabilities
- Governing body
- Subcontracts
- Provider network capacity and services
- Provider appeals
- Member services
- PCP assignments and changes
- Enrollee grievances and appeals

- Health education and promotion
- Quality improvement
- Utilization review
- Data reporting
- Coordination of care
- Claims processing
- Fraud and abuse

Each readiness review will be performed on site at the CCN's Louisiana administrative offices.

17.3. Ongoing Contract Monitoring

DHH will monitor the CCN's performance to assure the CCN is in compliance with the Contract provisions. However this does not relieve the CCN of its responsibility to continuously monitor its providers' performance in compliance with the Contract provisions.

DHH or its designee shall coordinate with the CCN to establish the scope of review, the review site, relevant time frames for obtaining information, and the criteria for review.

DHH or its designee will, at a minimum annually, monitor the operation of the CCN for compliance with the provisions of this Contract, and applicable federal and state laws and regulations. Inspection shall include the CCN's facilities, as well as auditing and/or review of all records developed under this Contract including, but not limited to, periodic medical audits, grievances, enrollments, disenrollment, termination, utilization and financial records, review of the management systems and procedures developed under this Contract and any other areas or materials relevant or pertaining to this Contract.

The CCN shall provide access to documentation, medical records, premises, and staff as deemed necessary by DHH.

The CCN shall have the right to review and comment on any of the findings and recommendations resulting from Contract monitoring and audits, except in the cases of fraud investigations or criminal action. However, once DHH finalizes the results of monitoring and/or audit report, the CCN must comply with all recommendations resulting from the review. Failure to comply with recommendations for improvement may result in monetary penalties, sanctions and/or enrollment restrictions.

17.4. Monitoring Reports

DHH will require CCNs to submit monthly, quarterly, and annual reports that will allow DHH to assess the CCN's performance.

17.5. Corrective Action

17.5.1. DHH may require a corrective action plan, as referenced in Section § 18.1.1.7, to be developed and approved by DHH in situations where intermediate sanctions may be imposed. DHH shall approve and monitor implementation of such a plan and set appropriate timelines to bring activities of the CCN into compliance with state and federal regulations. DHH may monitor via required reporting on a specified basis and/or through on-site evaluations, the effectiveness of the plan. Before imposing intermediate sanctions, DHH shall give the CCN timely written notice that explains the basis and nature of the sanction and any other due process protections that DHH elects to provide and shall provide notification to CMS.

17.5.2. Whenever monetary penalties for a single occurrence exceed $25,000.00, DHH staff will meet with CCN staff to discuss the causes for the occurrence and to negotiate a reasonable plan for corrective action of the occurrence. Once a corrective action plan has been approved by DHH, collection of monetary penalties during the agreed upon corrective action period will be suspended. The corrective action plan must include a date certain for the correction of the occurrence. Should that date for correction be missed by the CCN, the original schedule of monetary penalties will be reinstated, including collection of monetary penalties for the corrective action period, and monetary penalties will continue until satisfactory correction as determined by DHH of the occurrence has been made.

17.6. Inspection, Evaluation and Audit of Records

17.6.1. At any time, HHS, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, DHH, and/or any of the designees of the above, and as often as they may deem necessary during the term of the Contract and for a period of six (6) years from the expiration date of the Contract (including any contract extensions), shall have the right to inspect or otherwise

evaluate the quality, appropriateness, and timeliness of services provided under the terms of this and any other applicable rules.

17.6.2. The CCN and contracted providers shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have the right to examine and make copies, excerpts or transcripts from all records, contact and conduct private interviews with CCN clients and employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by this RFP.

17.6.3. The State and HHS may inspect and audit any financial records of the entity or its subcontractors. There shall be no restrictions on the right of the State or Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs.

17.6.4. The CCN and all of its contractors will make office work space available for any of the above-mentioned entities or their designees when the entities are inspecting or reviewing any records related to the provisions of services under this RFP. If any litigation, claim, or other action involving the records has been initiated prior to the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the six (6) year period, whichever is the later. This provision is applicable to any contractor and must be included in all contracts. DHH and/or any designee will also have the right to:

- Inspect and evaluate the qualifications and certification or licensure of CCN's contractors;

- Evaluate, through inspection of CCN and its contractor's facilities or otherwise, the appropriateness and adequacy of equipment and facilities for the provision of quality health care to members;

- Evaluate the CCN's performance for the purpose of determining compliance with the requirements of the Contract;

- Audit and inspect any of CCN's or its contractor's records that pertain to health care or other services performed as a result of this Contract; determine amounts payable; or the capacity of the CCN to bear the risk of financial losses;

- Audit and verify the sources of data and any other information furnished by the CCN in response to reporting requirements of this RFP, including data and information furnished by contractors;

- The CCN agrees to provide, upon request, all necessary assistance in the conduct of the evaluations, inspections, and audits.

- DHH shall monitor enrollment and termination practices and ensure proper implementation of the CCN's grievance procedures, in compliance with 42 CFR § 438.226-438.228. DHH and its designee shall have access to all information related to complaints and grievances and appeals filed by CCN members.

- The CCN agrees that all statements, reports and claims, financial and otherwise, shall be certified as true, accurate, and complete, and the CCN shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, this RFP, and DHH policy.

17.7. Medical Records Requirements

The CCN will require network providers/contractors to maintain up-to-date medical records at the site where medical services are provided for each enrolled CCN member. Each member's record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment. The CCN shall ensure within its own provider network that

DHH representatives or its designee shall have immediate and complete access to all records pertaining to the health care services provided to CCN members. Medical record requirements are further defined in this RFP. The CCN's Notice of Privacy Practices shall put members on notice that their information will be subject to treatment, payment and operations disclosures within the CCN.

17.8. Record Retention

All records originated or prepared in connection with CCN's performance of its obligations under the Contract, including but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by the CCN and its contractors in accordance with the terms and conditions of the Contract.

The CCN further agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of members relating to the delivery of care or service under this RFP, and as further required by DHH, for a period of six (6) years from the expiration date of the Contract, including any Contract extension(s). If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the six (6) year period, whichever is later. If the CCN stores records on microfilm or microfiche, CCN hereby agrees to produce at CCN's expense, legible hard copy records upon the request of state or federal authorities, within fifteen (15) calendar days of the request.

17.9. DHH Responsibilities

17.9.1. Administrative Oversight

DHH will be responsible for the administrative oversight of the Coordinated Care Networks. As appropriate, DHH will provide clarification of Coordinated Care Network requirements and Medicaid policy, regulations and procedures. DHH will be responsible for oversight of all functions resulting from this RFP. All Medicaid policy decision making or RFP interpretation will be made solely by the DHH. The Administrative oversight will be conducted in the best interests of DHH and the CCN members.

Whenever DHH is required by the terms of this RFP to provide written notice to the CCN, such notice will be signed by the Medicaid Deputy Director who oversees the Medicaid Coordinated Care Section or by the Medicaid Director.

17.9.1.1. Any notice given to a party under the Contract is deemed effective, if addressed to the party as addressed below, upon: (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by facsimile if a copy of the notice is sent by another means specified in this Section; (iii) the third Business Day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iv) the next Business Day after being sent by a nationally recognized overnight express courier with a reliable tracking system.

17.9.1.2. Either party may change its address where notices are to be sent by giving notice according to this Section.

17.9.1.3. Either party may change its address for notification purposes by providing written notice stating the change, effective date of change and setting forth the new address at least 10 days prior to the effective date of the change of address. If different representatives are designated after execution of the Contract, notice of the new representative will be given in writing to the other party and attached to originals of the Contract.

17.9.2. Payment of Enhanced Care Management PMPM Rate

The CCN shall be paid PMPM amounts for the eligibility group the member is assigned as specified in Appendix E.

17.9.3. Notification of Coordinated Care Network Program Policies and Procedures

DHH will provide the CCN with updates to appendices, information and interpretation of all pertinent federal and state Medicaid regulations, CCN policies, procedures and guidelines

affecting the provision of services described within this RFP. The CCN will submit written requests to DHH for additional clarification, interpretation or other information in a grid format specified by DHH. Provision of such information does not relieve the CCN of its obligation to keep informed of applicable federal and state laws related to its obligations under this RFP.

17.9.4. Quality Assessment and Monitoring Activities

- DHH will monitor the CCN's performance to assure the CCN is in compliance with the RFP contractual provisions. However this does not relieve the CCN of its responsibility to continuously monitor its provider's performance in compliance with the RFP contractual provisions.

- DHH or its designee shall coordinate with the CCN to establish the scope of review, the review site, relevant time frames for obtaining information, and the criteria for review.

- DHH or its designee will, at a minimum, annually monitor the operation of the CCN for compliance with the provisions the resulting Contract and applicable federal and state laws and regulations. Inspection shall include the CCN's facilities, as well as auditing and/or review of all records developed under the Contract including, but not limited to, periodic medical audits, grievances, enrollments, disenrollments, termination, utilization and financial records, review of the management systems and procedures developed under the Contract and any other areas or materials relevant or pertaining to the Contract.

- The CCN shall have the right to review any of the findings and recommendations resulting from Contract monitoring and audits, except in the cases of fraud investigations or criminal action. However, once DHH finalizes the results of monitoring and/or audit report, the CCN must comply with all recommendations resulting from the review. Failure to comply with recommendations for improvement may result in

monetary penalties, sanctions and/or enrollment restrictions.

17.9.5. Fee-for-Service to CCNs

DHH will be responsible for providing CCNs with a recent retrospective fee-for-service history on all current members, if available. This history will go back a maximum of twenty-four (24) months from the month of initial CCN membership. DHH's FI will post 820 files (HIPAA format equivalent of the CP-0-92) that the CCN will be able to download. The FI will keep twenty-four (24) months of rolling history available on this website. There will be NO printing/mailing of any claims history over twenty-four (24) months.

17.9.6. Request for Corrective Action Plan

The DHH will monitor the CCN's quality care outcome activities and corrective actions taken as specified in the CCN Quality Assessment Plan in this RFP.

The CCN must make provisions for prompt response to any detected deficiencies or Contract violations and for the development of corrective action initiatives relating to this Contract.

17.9.7. External Quality Review

DHH will perform periodic medical audits through contractual arrangements to determine if the CCN furnished quality and accessible health care to CCN members as described in 42 CFR 438.358. DHH will contract with an External Quality Review Organization (EQRO) to perform the periodic medical audits and external independent reviews.

17.9.8. Marketing

DHH, and/or its designee shall have the right to approve, disapprove or require modification of all marketing plans, materials, and activities, enrollment and member handbook materials developed by the CCN under the Contract and prior to implementation and/or distribution by the CCN. See § 11 of this RFP.

17.9.9. Grievances

DHH shall have the right to approve, disapprove or require modification of all grievance procedures submitted with this RFP. DHH requires the CCN to meet and/or exceed the CCN grievance standards as outlined in § 11 of this RFP.

17.9.10. Training

DHH will conduct provider training and workshops on Coordinated Care Program policy and procedures as deemed appropriate for CCNs.

17.9.11. Emergency Services

- DHH will cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the CCN.

- DHH will not deny payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR § 438.114(a) of the definition of emergency medical condition.

- DHH will not deny payment for treatment obtained when a representative of the CCN instructs the enrollee to seek emergency services.

- DHH will not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms in accordance with 42 CFR § 438.114(b).

- DHH will not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's CCN or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services as specified in 42 CFR § 438.114(b).

17.10. Audit Requirements for Coordinated Care Networks

17.10.1. Audit of Services

The CCN and its subcontracts shall comply with all audit requirements specified in the Contract and department issued guides.

The CCN and its subcontractor shall maintain supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state requirements, and are sufficient to ensure the accuracy and validity of claims.

Such documents, including all original claim forms, shall be maintained and retained by the CCN and or its subcontractors for a period of six (6) years after the contract expiration date or until the resolution of all litigation, claim, financial management review or audit pertaining to the Contract, whichever is longer.

There shall be no restrictions on the right of the state and federal government to conduct inspections and audits as deemed necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs.

The CCN or its subcontractors shall provide any assistance that such auditors and inspectors reasonably may require to complete with such audits or inspections.

Upon reasonable notice, CCN and its subcontractors shall provide the officials and entities identified in the Contract and department issued guides with prompt, reasonable, and adequate access to any records, books, documents, and papers that are related to the performance of the Contract.

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18. ADMINISTRATIVE ACTIONS, MONETARY PENALITES & SANCTIONS

18.1. DHH Administrative Actions

18.1.1. DHH shall notify the CCN through a written Notice of Action when it is determined the CCN is deficient or non-compliant with requirements of the Contract. Administrative actions exclude monetary penalties, intermediate actions and termination and include, but are not limited to:

18.1.1.1. A warning through written notice or consultation;

18.1.1.2. Education requirement regarding program policies and billing procedures; The CCN may be required by DHH to participate in a provider education program as a condition of continued participation. CCN education programs may include a letter of warning or clarification on the use and format of provider manuals; instruction on the use of procedure codes; review of key provisions of the Medicaid Program; instruction on reimbursement rates; instructions on how to inquire about coding or billing problems; and quality/medical issues;

18.1.1.3. Review of prior authorization implementation processes;

18.1.1.4. Referral to the appropriate State licensing agency (Department of Insurance) for investigation;

18.1.1.5. Referral for review by appropriate professional organizations;

18.1.1.6. Referral to the Office of the Attorney General for fraud investigation; and/or

18.1.1.7. Require submission of a corrective action plan.

18.2. DHH Monetary Penalties

18.2.1. The purpose of establishing and imposing monetary penalties is to provide a means for DHH to obtain the services and level of performance required for successful operation of the

Contract. DHH's failure to assess monetary penalties in one or more of the particular instances described herein will in no event waive the right for DHH to assess additional monetary penalties or actual damages.

18.2.2. The decision to impose monetary penalties shall include consideration of the following factors:

18.2.2.1. The duration of the violation;

18.2.2.2. Whether the violation (or one that is substantially similar) has previously occurred;

18.2.2.3. The CCN's history of compliance;

18.2.2.4. The severity of the violation and whether it imposes an immediate threat to the health or safety of the Medicaid members; and

18.2.2.5. The "good faith" exercised by the CCN in attempting to stay in compliance.

18.2.3. For purposes of this section, violations including individual, unrelated enrollees shall **not** be considered arising out of the same action.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**SANCTION**
Operations Start Date	Ten thousand dollars ($10,000.00) per calendar day for each day beyond the Operations Start date that the CCN is not operational until the day that the CCN is operational, including all systems.
Operations Readiness	Final versions of the Provider Directory must be submitted no later than date specified in the Schedule of Events of this RFP. One thousand ($1,000.00) per calendar day for each day the directory is late, inaccurate or incomplete.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**SANCTION**
System Readiness Review – CCN must submit to DHH or the Readiness Review Contractor the following plans no later than 120 days prior to Operational Start Date: • Disaster Recovery Plan • Business Continuity Plan • Systems Quality Assurance Plan	One thousand ($1,000.00) per calendar day for each day a deliverable is late, inaccurate, or incomplete.
Quality Assessment and Performance Improvement Reports	Two thousand dollars ($2,000.00) per report for each calendar day the Quality Assessment and Performance Improvement Plan (QAPI), performance measure, and/or performance improvement project reports are late or incorrect as outlined in this RFP and the *Quality Companion Guide*.
Timely Claims Pre-Processing	Ninety-nine percent (99%) submission rate of all clean claims received forwarded and received by the FI within two (2) business days. Five thousand dollars ($5,000.00) for the first quarter that a CCN's claims preprocessing performance percentages by GSA fall below the performance standard. Twenty-five thousand dollars ($25,000.00) per quarter for each additional quarter that the claims preprocessing performance percentages by GSA fall below the performance standards.
Patient Center Medical Home Plan Reports	One thousand dollars ($1,000.00) per calendar day for each day the Patient Center Medical Home Plan is received after the due date.
Member and/or Provider Satisfaction Report(s)	Two thousand dollars ($2,000.00) per calendar day for each calendar day the report(s) are late are incorrect.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**SANCTION**
Member Services Activities	Five thousand dollars ($5,000.00) per calendar day for failure to provide access to primary care providers that offer extended office hours (minimum of 2 hours) at least one day per week (after 5:00 pm Central Time) and on Saturdays [a minimum of four (4) hours]. Five thousand dollars ($5,000.00) per calendar day for failure to provide member services functions from 7 a.m. to 7 p. m. Central Standard Time, Monday through Friday, to address non-emergency issues encountered by members, and 24 hours a day, 7 days a week to address emergency issues encountered by members. Five thousand dollars ($5,000.00) per calendar day for failure to operate a toll-free hotline that members can call 24 hours a day, seven (7) days a week.
Member Call Center • Answer 95% of calls within 30 seconds • Maintain an average hold time of 3 minutes or less • Maintain abandoned rate of calls of not more than 5%	One hundred dollars ($100.00) for each percentage point for each standard that fails to meet the requirements for a monthly reporting period per CCN. One hundred dollars ($100.00) for each 30 second time increment, or portion thereof, by which the CCNs average hold time exceeds the maximum acceptable hold time per CCN.
Provider Demographics Report	Five thousand dollars ($5,000.00) per calendar day for failure to provide and validate provider demographic data on a quarterly basis to ensure current, accurate, and clean data is on file for all contracted providers.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**SANCTION**
Provider Service Activities	Five thousand dollars ($5,000.00) per calendar day for failure to provide for arrangements to handle emergent provider issues on a twenty-four (24) hour, seven (7) days-a-week basis. Five thousand dollars ($5,000.00) per calendar day for failure to furnish provider services functions from 7 a.m. to 7 p.m. Central Time, Monday through Friday to address non-emergency issues encountered by providers.
Emergency Management Plan	Ten thousand dollars ($10,000.00) per calendar day for each day the Emergency Management Plan as specified in this RFP is received after the due date or up to one hundred thousand dollars ($100,000) for failure to submit timely. However DHH may assess an additional two hundred thousand dollars ($200,000) for failure to submit the plan prior to the beginning of the Atlantic hurricane season (June 1st).
Termination Transition Plan	Six months prior to the end of the Contract period or any extension thereof or if earlier, within thirty (30) days of Notice of Termination. One thousand dollars ($1,000.00) per calendar day the plan is late, inaccurate, or incomplete.
Ad Hoc Reports.	As required by this Contract or upon request by DHH and mutually agreed upon by the CCN. Two thousand dollars ($2,000.00) per calendar day for each business day that a report is late or incorrect.

18.2.4. DHH shall utilize the following guidelines to determine whether a report is correct and complete:

18.2.4.1. The report must contain 100% of the CCN's data;

18.2.4.2. 99% of the required items for the report must be completed; and

18.2.4.3. 99.5% of the data for the report must be accurate as determined by edit specifications/review guidelines set forth by DHH.

18.3. **DHH Monetary Penalties for Noncompliance with Other Timely Reporting or Deliverable Requirements**

18.3.1. For each day that a deliverable is late, incorrect or deficient, the CCN may be liable to DHH for monetary penalties in an amount per calendar day per deliverable as specified in the table below for reports and deliverables not otherwise specified in the above Table of Monetary Penalties.

18.3.2. Monetary penalties have been designed to escalate by duration and by occurrence over the term of this Contract.

Occurrence	Daily Amount for Days 1 - 14	Daily Amount for Days 15-30	Daily Amount for Days 31-60	Daily Amount for Days 61 and Beyond
1-3	$ 750	$ 1,200	$ 2,000	$ 3,000
4-6	$ 1,000	$ 1,500	$ 3,000	$ 5,000
7-9	$ 1,500	$ 2,000	$ 4,000	$ 6,000
10-12	$ 1,750	$ 3,500	$ 5,000	$ 7,500
13 and Beyond	$ 2,000	$ 4,000	$ 7,500	$10,000

18.4. DHH Monetary Penalties Related to Noncompliance of Employment of Key Personnel and Licensed Personnel

18.4.1. Seven hundred dollars ($700.00) per calendar day for failure to have a full-time acting or permanent Administrator/CEO for more than seven (7) consecutive calendar days for each day the Administrator/CEO has not been appointed;

18.4.2. Seven hundred dollars ($ 700.00) per calendar day for failure to have a full-time acting or permanent Medical Director for more than seven (7) consecutive calendar days for each day the medical director has not been appointed.

18.4.3. Two hundred fifty dollars ($250.00) per calendar day for each day that personnel are not licensed as required by applicable state and federal laws and/or regulations.

18.5. Monetary Penalties for Excess Reversals on Appeal

Twenty-five thousand dollars ($25,000.00) for exceeding ten percent (10%) member appeals over a twelve month period (January – December) which have been overturned in a final appeal outcome; or for each occurrence in which the CCN does not provide the medical services or requirements set forth in the final outcome of the administrative decision by DHH or the appeals decision of the State Fair Hearing.

18.6. Penalties for Failure to Comply with Marketing and Member Education Requirements

18.6.1. Whenever DHH determines that the CCN its agents, subcontractors, volunteers or providers has engaged in any unfair, deceptive, or prohibited marketing or member education practices in connection with proposing, offering, selling, soliciting, and providing any health care services, one or more of the remedial actions listed below shall apply.

18.6.2. Unfair, deceptive, or prohibited marketing practices shall include, but is not limited to:

18.6.2.1. Failure to secure written approval before distributing marketing or member education materials;

18.6.2.2. Engaging in, encouraging or facilitating prohibited marketing by a provider;

18.6.2.3. Directly marketing to eligibles or potential eligibles;

18.6.2.4. Failure to meet time requirements for communication with new members (distribution of welcome packets, welcome calls);

18.6.2.5. Failure to provide interpretation services or make materials available in required languages.

18.6.2.6. Engaging in any of the prohibited marketing and member education practices detailed in this RFP;

18.6.2.7. False, misleading oral or written statement, visual description, advertisement, or other representation of any kind which has the capacity, tendency, or effect of deceiving or misleading CCN potential enrollees or enrollees with respect to any health care services, CCN or health care provider; or the DHH Coordinated Care Program;

18.6.2.8. Representation that a CCN or network provider offers any service, benefit, access to care, or choice which it does not have;

18.6.2.9. Representation that a CCN or health care provider has any status, certification, qualification, sponsorship, affiliation, or licensure which it does not have;

18.6.2.10. Failure to state a material fact if the failure deceives or tends to deceive;

18.6.2.11. Offering any kickback, bribe, award, or benefit to any Medicaid eligible as an inducement to select, or to refrain from selecting any health care service, CCN, or health care provider; and

18.6.2.12. Use of the Medicaid eligibles or another person's information which is confidential, privileged, or which cannot be disclosed to or obtained by the user without violating a state or federal confidentiality law, including:

a. Medical records information, and

b. Information which identifies the recipient or any member of his or her group as a recipient of any government sponsored or mandated health coverage program; and

18.6.2.13. Use of any device or artifice in advertising a CCN or soliciting a Medicaid eligible which misrepresents the solicitor's profession, status, affiliation, or mission.

18.7. **Remedial Action(s) for Marketing Violations**

DHH shall notify the CCN in writing of the determination of the non-compliance, of the remedial action(s) that must be taken, and of any other conditions related such as the length of time the remedial actions shall continue and of the corrective actions that the CCN must perform.

18.7.1. DHH may require the CCN to recall the previously authorized marketing material(s);

18.7.2. DHH may suspend enrollment of new members to the CCN;

18.7.3. DHH may deduct the amount of enhanced primary care case management fee for members enrolled as a result of non-compliant marketing practices from the next monthly capitation payment made to the CCN and shall continue to deduct such payment until correction of the failure;

18.7.4. DHH may require the CCN to contact each member who enrolled during the period while the CCN 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 CCN; or

18.7.5. DHH may prohibit future marketing activities by the CCN for an amount of time specified by DHH.

18.8. Monetary Penalties for Failure to Provide Core Benefits and Services

In the event that DHH determines that the CCN failed to provide one or more core benefits and services, DHH shall direct the CCN to provide such service. If the CCN continues to refuse to provide the core benefit or service(s), DHH shall authorize the members to obtain the covered service from another source and shall notify the CCN in writing that the CCN shall be charged the actual amount of the cost of such service. In such event, the charges to the CCN shall be obtained by DHH in the form of deductions of that amount from the next monthly capitation payment made to the CCN. With such deductions, DHH shall provide a list of the members from whom payments were deducted, the nature of the service(s) denied, and payments DHH made or will make to provide the medically necessary covered services.

18.9. DHH Intermediate Sanctions

18.9.1. DHH shall notify the CCN and CMS in writing of its intent to impose sanctions for violating the terms and conditions of the Contract or violation of federal Medicaid rules and regulations and will explain the process for the CCN to employ the dispute resolution process as described in this RFP. The following are non-exhaustive grounds for which intermediate sanctions may be imposed when a CCN acts or fails to act. The CCN:

18.9.1.1. Fails substantially to provide medically necessary services that the CCN is required to provide, under law or under the Contract, to a member covered under the Contract;

18.9.1.2. Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Louisiana Medicaid CCN Program;

18.9.1.3. Acts to discriminate among members on the basis of their health status or need for health care services; this includes termination of enrollment or refusal to reenroll a member,

except for reasons in §10 of this RFP, or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future medical services.

18.9.1.4. Misrepresents or falsifies information that it furnishes to CMS or to DHH;

18.9.1.5. Misrepresents or falsifies information that it furnishes to a member, potential member, or a health care provider;

18.9.1.6. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR §422.208 and 422.210;

18.9.1.7. Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by DHH or that contain false or materially misleading information; or

18.9.1.8. Violates any of the other applicable requirements of sections 1903(m). 1905(t)(3) or 1932 of the Social Security Act and any implementing regulations.

18.9.2. The intermediate sanctions that DHH may impose upon the CCN shall be in accordance with §1932 of the Social Security Act (42 U.S.C. §1396u-2) and 42 CFR Part 438, Subpart I as those requirements apply to PCCMs and may include any of the following:

18.9.2.1. Civil monetary penalties in the following specified amounts:

18.9.2.1.1. A maximum of $25,000 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 physician incentive plan requirements; or marketing violations;

18.9.2.1.2. A maximum of $100,000 for each determination of discrimination among members on the basis of their health status or need for services; or misrepresentation or falsification to CMS or DHH;

18.9.2.1.3. A maximum of $15,000 for each member DHH determines was discriminated against based on the member's health status or need for services (subject to the $100,000 limit above);

18.9.2.1.4. A maximum of $25,000 or double the amount of the excess charges (whichever is greater), for charging premiums or charges in excess of the amounts permitted under the Louisiana Medicaid CCN Program. DHH shall return the amount of overcharge to the affected member(s);

18.9.2.2. Appointment of temporary management for a CCN as provided in 42 CFR 438.706;

18.9.2.3. Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll;

18.9.2.4. Suspension of all new enrollments, including automatic assignment, after the effective date of the sanction;

18.9.2.5. Suspension of payment for members enrolled after the effective date of the sanction and until

CMS or DHH is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

18.9.2.6. Additional sanctions allowed under state statutes or regulations that address areas of noncompliance. described above.

18.9.3. The following factors will be considered in determining sanction(s) to be imposed:

18.9.3.1. Seriousness of the offense(s);

18.9.3.2. Patient quality of care issues;

18.9.3.3. Failure to perform administrative functions;

18.9.3.4. Extent of violations; history of prior violations; prior imposition of sanctions;

18.9.3.5. Prior provision of provider education; provider willingness to obey program rules;

18.9.3.6. Whether a lesser sanction will be sufficient to remedy the problem; and

18.9.3.7. Actions taken or recommended by peer review groups or licensing boards.

18.10. **<u>Misconduct for Which Sanctions May Be Imposed</u>**

18.10.1. DHH may impose sanctions against any CCN if the agency finds any of the following non-exclusive actions/occurrences:

18.10.1.1. The CCN has failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from DHH;

18.10.1.2. The CCN has been excluded from participation in Medicare because of fraudulent or abusive practices pursuant to Public Law 95-142;

18.10.1.3. The CCN, or any of its owners, officers or directors has been convicted of a criminal offense relating to performance of the Contract with DHH or of fraudulent billing practices or of negligent practice resulting in death or injury to the CCN's member;

18.10.1.4. The CCN has presented, or has caused to be presented, any false or fraudulent claim for services or has submitted or has caused to be submitted false information to be furnished to the State or the Secretary of federal Department of Health and Human Services;

18.10.1.5. The CCN has engaged in a practice of charging and accepting payment (in whole or part) from members for services for which a PMPM payment was made by DHH;

18.10.1.6. The CCN has rebated or accepted a fee or portion of fee or charge for a patient referral;

18.10.1.7. The CCN has failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments;

18.10.1.8. The CCN has failed to keep or make available for inspection, audit or copying, such records regarding payments claimed for providing services;

18.10.1.9. The CCN has failed to furnish any information requested by DHH regarding payments for providing goods or services;

18.10.1.10. The CCN has made, or caused to be made, any false statement or representation of a material fact to DHH or CMS in connection with the administration of the Contract; and

18.10.1.11. The CCN has furnished goods or services to a member which at the sole discretion of DHH,

and based on competent medical judgment and evaluation are determined to be 1) insufficient for his or her needs, 2) harmful to the member, or 3) of grossly inferior quality.

18.10.2. DHH may require a corrective action plan, as referenced in section 2.29.4, to be developed and approved by DHH in situations where intermediate sanctions may be imposed. DHH shall approve and monitor implementation of such a plan and set appropriate timelines to bring activities of the CCN into compliance with state and federal regulations. DHH may monitor via required reporting on a specified basis and/or through on-site evaluations, the effectiveness of the plan. Before imposing intermediate sanctions, DHH shall give the CCN timely written notice that explains the basis and nature of the sanction and any other due process protections that DHH elects to provide and shall provide notification to CMS.

18.11. Notice to CMS

DHH will give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed in §438.700 specifying the affected CCN, the kind of sanction, and the reason for DHH's decision to lift a sanction. Notice will be given no later than thirty (30) days after DHH imposes or lifts the sanction.

18.12. Federal Sanctions

Section 1903(m)(5)(A) and (B) of the Social Security Act vests the Secretary of the Department of Health and Human Services with the authority to deny Medicaid payments to a health plan for members who enroll after the date on which the health plan has been found to have committed one or more of the violations identified below. Therefore, whenever, and for so long as, federal payments are denied, DHH shall deduct the total amount of federal payments denied from the next monthly capitation payment made to the CCN.

18.12.1. Substantial failure to provide required medically necessary items or services when the failure had adversely affected (or has substantial likelihood of adversely affecting) a member,

18.12.2. Discrimination among members with respect to enrollment, re-enrollment, or disenrollment on the basis of the member's health status or requirements for health care services,

18.12.3. Misrepresentation or falsification of certain information, or

18.12.4. Failure to comply with the requirements for physician incentive plans as specified herein.

18.13. <u>Payment of Monetary Penalties</u>

18.13.1. Any monetary penalties assessed by DHH that cannot be collected through withholding from future PMPM payments shall be due and payable to DHH within thirty (30) calendar days after the CCN's receipt of the notice of monetary penalties. However, in the event an appeal by the CCN results in a decision in favor of the CCN, any such funds withheld by DHH will be returned to the CCN.

18.13.2. If monetary penalties are insufficient, DHH has the right to pursue actual damages. If the CCN's failure to perform satisfactorily exposes DHH to the likelihood of contracting with another person or entity to perform services required of the CCN under this Contract, upon notice setting forth the services and retainage, DHH may withhold from the CCN payments in an amount commensurate with the costs anticipated to be incurred. DHH shall account to the CCN and return any excess to the CCN. If retainage is not sufficient, the CCN shall immediately reimburse DHH the difference or DHH may offset from any payments due the CCN. The CCN will cooperate fully with DHH and provide any assistance it needs to implement the terms of its agreement for services for retainage.

18.13.3. DHH has the right to recovery of any amounts overpaid as the result of deceptive practices by the CCN and/or its contractors, and may consider trebled damages, civil penalties, and/or other remedial measures.

18.13.4. A monetary sanction may be applied to all known affiliates, subsidiaries and parents of a CCN, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and

circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the CCN is affiliated where such conduct was accomplished within the course of his official duty or was effectuated by him with the knowledge or approval of such person.

18.14. Corrective Action

Whenever monetary penalties for a single occurrence exceed $25,000.00, DHH staff will meet with CCN staff to discuss the causes for the occurrence and to negotiate a reasonable plan for corrective action of the occurrence. Once a corrective action plan has been approved by DHH, collection of monetary penalties during the agreed upon corrective action period will be suspended. The corrective action plan must include a date certain for the correction of the occurrence. Should that date for correction be missed by the CCN, the original schedule of monetary penalties will be reinstated, including collection of monetary penalties for the corrective action period, and monetary penalties will continue until satisfactory correction as determined by DHH of the occurrence has been made.

18.15. Termination of CCN Contract

Nothing in this section shall limit DHH's right to terminate the Contract or to pursue any other legal or equitable remedies. Pursuant to 42 CFR 438.708, DHH may terminate the Contract as a sanction and enroll that CCN's members in other CCNs or provide their benefits through other options included in the state plan if DHH, at its sole discretion, determines that the CCN has failed to 1) carry out the substantive terms of the Contract or 2) meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Social Security Act.

18.16. Termination for Cause

18.16.1. DHH may terminate the Contract when DHH determines the CCN and/or CCN subcontractor(s) have failed to perform, or have violated, substantive terms of the Contract and have failed to meet federal or state requirements.

18.16.2. DHH will provide the CCN with a timely written Notice of Intent to Terminate (Notice). In accordance with 42 CFR §438.708, the Notice will state the nature and basis of the sanction, pre-termination hearing and dispute resolution conference rights, and the time and place of the hearing.

18.16.3. The termination will be effective no less than thirty (30) calendar days from the date of the Notice. The CCN may, at the discretion of DHH, be allowed to correct the deficiencies within the thirty (30) calendar day notice period, unless other provisions in this section demand otherwise, prior to the issuance of a Notice of Termination.

18.16.4. In accordance with 42 CFR §438.708, DHH will conduct a pre-termination hearing upon the request of the CCN as outlined in the Notice to provide CCN the opportunity to contest the nature and basis of the sanction. The CCN may request a pre-termination hearing with the CCN Program Director and/or a dispute resolution conference before the DHH Undersecretary prior to the determined date of termination stated in the Notice.

18.16.5. The CCN shall receive a written notice of the outcome of the pre-termination hearing and/or dispute resolution conference, indicating decision reversal or affirmation.

18.16.6. The decision by the DHH Undersecretary is the exclusive remedy and LA R.S. 49:950-999.25, the Administrative Procedure Act, does not apply. The Notice of Termination will state the effective date of termination.

18.16.7. DHH will notify the Medicaid members enrolled in the CCN, consistent with 42 CFR §438.710, of the affirming termination decision and of their options for receiving Medicaid services and initiating the reenrollment process.

18.17. <u>Termination Due to Serious Threat to Health of Members</u>

DHH may terminate this Contract immediately if it is determined that actions by the CCN or its subcontractor(s) pose a serious threat to the health of members enrolled in the CCN. The CCN members will be given an opportunity to enroll in another CCN (if there is capacity) or move to fee-for-service.

18.18. <u>Termination for CCN Insolvency, Bankruptcy, Instability of Funds</u>

18.18.1. The CCN's insolvency or the filing of a petition in bankruptcy by or against the CCN shall constitute grounds

for termination for cause. If DHH determines the CCN has become financially unstable, DHH will immediately terminate this Contract upon written notice to the CCN effective the close of business on the date specified.

18.18.2. The CCN shall cover continuation of services to members for the duration of any period for which payment has been made, as well as for inpatient admissions up until discharge.

18.19. Termination for Ownership Violations

The CCN is subject to termination, unless the CCN can demonstrate changes of ownership or control, when:

18.19.1. A person with a direct or indirect ownership interest in the CCN:

18.19.1.1. Has been convicted of a criminal offense under §§1128(a) and 1128(b)(1), or (3) of the Social Security Act, in accordance with 42 CFR §1002.203;

18.19.1.2. Has had civil monetary penalties or assessment imposed under § 1128A of the Act; or

18.19.1.3. Has been excluded from participation in Medicare or any State health care program.

18.19.2. Any individual who has a direct or indirect ownership interest or any combination thereof of 5% or more, or who is an officer if the CCN is organized as a corporation or who is a partner, if it is organized as a partnership, or is an agent or a managing employee, has one of the conditions specified in 1 - 3 above.

18.19.3. The CCN has a direct or indirect substantial contractual relationship with an excluded individual or entity. "Substantial contractual relationship" is defined as any direct or indirect business transactions that amount in a single fiscal year to more than $25,000 or 5% of the CCN's total operating expenses, whichever is less.

18.20. Turnover Requirements

The CCN shall comply with all requirements specified in Appendix JJ – Turnover Requirements. The turnover requirements in this Appendix are applicable upon any termination of the Contract when:

18.20.1. Initiated by the CCN as allowed in §18.18 and §18.19 of this RFP;

18.20.2. Initiated by DHH, or

18.20.3. At the end of the contract period.

In accordance with 42 CFR §434.6(a)(6), the CCN shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims.

18.21. Payment of Outstanding Monies or Collections from CCN

The CCN will be paid for any outstanding monies due less any assessed monetary penalties. If monetary penalties exceed monies due, collection can be made from the CCN Fidelity Bond, Performance Bond, Errors and Omissions Insurance, or any insurance policy or policies required under this Contract. The rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

19. TERMS AND CONDITIONS

The CCN agrees to comply with all state and federal laws, regulations, and policies as they exist or as amended that are or may be applicable to this RFP, including those not specifically mentioned in this section. Any provision of this RFP which is in conflict with federal statutes, regulations, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and federal policy. Such amendment of the RFP will be effective on the effective date of the statutes, regulations, or policy statement necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties. The CCN may request DHH to make policy determinations required for proper performance of the services under this RFP.

19.1. Contract Term

19.1.1. Effective Date

The contract effective date shall be January 1, 2012 through December 31, 2014; unless terminated prior to that date in accordance with state or federal law or terms of the Contract. The CCN shall successfully complete a readiness review as specified in § 17.2 of this RFP prior to the effective date in the time frame specified by the Department in the Schedule of Events. If the CCN does not pass the readiness review the Contract shall be terminated by DHH.

19.1.2. Extensions

In accordance with 42 CFR 438.610(c)(3) DHH may not renew or otherwise extend the duration of an existing agreement unless the Secretary of HHS provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

If the CCN is in compliance 42 CFR §438.610(a) and upon mutual agreement of both parties, this Contract may be renewed for a subsequent two (2) twelve month periods.

Although there may be an extension for an additional two (2) twelve (12) month period; however, all contracts extending beyond the original 36 months must be approved by the Joint Legislative Committee on the Budget (JLCB), or as authorized by applicable law. The continuation of this Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Contract.

19.2. Liaisons

The CCN shall designate an employee of its administrative staff to act as the liaison between the CCN and DHH for the duration of the Contract. DHH's Medicaid Coordinated Care Section will be CCN's point of contact and shall receive all inquiries and requests for interpretation regarding the Contract and all required reports unless otherwise specified in the Contract. The CCN shall also designate a member of its senior management who shall act as a liaison between the CCN's senior management and DHH when such communication is required. If

different representatives are designated after approval of the Contract, notice of the new representative shall be provided in writing within seven (7) calendar days of the designation.

19.3. Assessment Of Fees

DHH may elect to deduct any assessed fees from payments due or owing to the CCN or direct the CCN to make payment directly to DHH for any and all assessed fees. The choice is solely and strictly DHH's choice.

19.4. Amendments

The Contract may be amended at any time as provided in this paragraph. The Contract may be amended whenever appropriate to comply with state and federal requirements or state budget reductions provided however that rates must be certified as actuarially sound. No modification or change of any provision of the Contract shall be made or construed to have been made unless such modification is mutually agreed to in writing signed by authorized representatives of the CCN and DHH, and incorporated as a written amendment to the Contract. Any amendment to the Contract shall require approval by DHH, the Division of Administration Office of Contractual Review and may require approval from the CMS Regional Office prior to the amendment implementation.

19.5. Applicable Laws and Regulations

The CCN agrees to comply with all applicable federal and state laws and regulations including Constitutional provisions regarding due process and equal protection under the laws and including but not limited to:

19.5.1. Title 42 Code of Federal Regulations (CFR) Chapter IV, Subchapter C (Medical Assistance Programs);

19.5.2. All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. 7401, et seq.) and 20 USC § 6082(2) of the Pro-Children Act of 1994, as amended (P.L. 103-227);

19.5.3. Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. 2000d) and regulations issued pursuant thereto, 45 CFR part 80; In accordance with Title VI of the Civil Rights Act of 1964 (42U.S.C. 2000d et seq.) and its implementing regulation at 45 C.F.R. Part 80, the Provider must take adequate steps to ensure

that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this agreement.

19.5.4. Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. 2000e) in regard to employees or applicants for employment;

19.5.5. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 CFR Part 84;

19.5.6. The Age Discrimination Act of 1975, as amended, 42 U.S.C 6101 et seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance;

19.5.7. The Omnibus Budget Reconciliation Act of 1981, as amended, P.L.E.97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance;

19.5.8. The Balanced Budget Act of 1997, as amended, P.L. 105-33 and the Balanced Budget Refinement Act of 1999, as amended, H.R. 3426;

19.5.9. Americans with Disabilities Act, as amended, 42 U.S.C. § 12101 et seq., and regulations issued pursuant thereto;

19.5.10. Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusion of CCNs for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;

19.5.11. Drug Free Workplace Acts, S.C. Code Ann. § 44-107-10 et seq. (Supp. 2000, as amended), and the Federal Drug Free Workplace Act of 1988 as set forth in 45 CFR Part 82,;

19.5.12. Title IX of the Education Amendments of 1972 regarding education programs and activities; and

19.5.13. The Byrd Anti-Lobbying Amendment- Contractors who apply or bid shall file the require certification that each tier will not use Federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any Federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded form tier to tier up to the recipient (45 CFR Part 3).

19.6. Attorney's Fees

In the event DHH should prevail in any legal action arising out of the performance or non-performance of the Contract, the CCN shall pay, in addition to any monetary penalties, all expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

19.7. Board Resolution/Signature Authority

The CCN if a corporation shall secure and attach to the Contract a formal Board Resolution indicating the signatory to the Contract is a corporate representative and authorized to sign said Contract.

19.8. Confidentiality of Information

19.8.1. The CCN shall assure that all material and information, in particular information relating to members or potential members, which is provided to or obtained by or through the CCN's performance under this Contract, whether verbal, written, electronic file, or otherwise, shall be treated as confidential information to the extent confidential treatment is provided under state and federal laws and regulations. The CCN shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Contract.

19.8.2. All information as to personal facts and circumstances concerning members or potential members obtained by the

CCN shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of DHH or the member/potential member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of this Contract.

19.9. Conflict of Interest

19.9.1. The CCN may not contract with Louisiana Medicaid unless such safeguards at least equal to federal safeguards (41 USC 423, section 27) are in place per State Medicaid Director letter dated December 30, 1997 and Section 1932 (d)(3) of the Social Security Act addressing Section 1932 State Plan Amendment and the default enrollment process under the State Plan Amendment option.

19.9.2. The CCN shall comply with requirements for physician incentive plans, as required by 42 CFR 438.6(h) and set forth (for Medicare) in 42 CFR 422.208 and 422.210.

19.10. Copyrights

If any copyrightable material is developed in the course of or under this Contract, DHH shall have a royalty free, non-exclusive, and irrevocable right to reproduce, publish, or otherwise use the work for DHH purposes.

19.11. Corporation

If the CCN is a corporation, the following requirement must be met prior to execution of the Contract:

19.11.1. If a for-profit corporation whose stock is not publicly traded-the CCN must file a Disclosure of Ownership form with the Louisiana Secretary of State.

19.11.2. If the CCN is a corporation not incorporated under the laws of the State of Louisiana-the CCN must obtain a Certificate of Authority pursuant to R.S. 12:301-302 from the Louisiana Secretary of State.

19.11.3. The CCN must provide written assurance to the agency from CCN's legal counsel that the CCN is not prohibited by its articles of incorporation, bylaws or the laws under which it is incorporated from performing the services required under the Contract.

19.12. Contract Language Interpretation

In the event of a disagreement regarding, arising out of, or related to, Contract language interpretation, DHH's interpretation of the Contract language in dispute shall control and govern. DHH's interpretation of the Contract language in dispute shall not be subject to Appeal under any circumstance.

19.13. Cooperation With Other Contractors

In the event that DHH has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder including but not limited to fiscal intermediary and enrollment broker services, the Contractor agrees to cooperate fully with such other contractors. The CCN shall not commit any act that will interfere with the performance of work by any other contractor.

The CCN's failure to cooperate and comply with this provision, shall be sufficient grounds for DHH to halt all payments due or owing to the Contractor until it becomes compliant with this or any other contract provision. DHH's determination on the matter shall be conclusive and not subject to Appeal.

19.14. Debarment/Suspension/Exclusion

19.14.1. The CCN agrees to comply with all applicable provisions of 42 CFR Part 376 (2009, as amended), pertaining to debarment and/or suspension. As a condition of enrollment, the CCN shall screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or all federal health care programs. To help make this determination, the CCN may search the following websites: Office of Inspector General (OIG) List of Excluded Individuals/Entities) LEIE

http://www.oig.hhs.gov/fraud/exclusions.asp; the Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.html and/or the Excluded Parties List Serve (EPLS) http://www.epls.gov.

19.14.2. The CCN shall conduct a search of the website monthly to capture exclusions and reinstatements that have occurred since the last search and any exclusion information discovered should be immediately reported to DHH. Any individual or entity that employs or subcontracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into provider contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR §1003.102(a)(2).

19.15. Effect of Termination on CCN's HIPAA Privacy Requirements

19.15.1. Except as provided in §14.4.2, upon termination of this Contract for any reason, the CCN shall return or destroy all Protected Health Information received from DHH, or created or received by the CCN on behalf of DHH. This provision shall also apply to Protected Health Information that is in the possession of subcontractors or of agents the CCN. The CCN shall not retain any copies of the Protected Health Information.

19.15.2. In the event that the CCN determines that returning or destroying the Protected Health Information is not feasible, the CCN shall provide to DHH notification of the conditions that make return or destruction not feasible. Upon a mutual determination that return or destruction of Protected Health Information is not feasible, the CCN shall extend the protections of the Contract to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the

return or destruction not feasible, for so long as the CCN maintains such Protected Health Information.

19.16. Employee Education about False Claims Recovery

If the CCN receives annual Medicaid payments of at least $5,000,000, the CCN must comply with Section 6032 of the Deficit Reduction Act (DRA) of 2005.

19.17. Employment of Personnel

19.17.1. In all hiring or employment made possible by or resulting from this Contract, the CCN agrees that:

19.17.1.1. There shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, or national origin; and

19.17.1.2. Affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all state and federal laws applicable to employment of personnel.

19.17.2. This requirement shall apply to, but not be limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff, termination, rates of pay or other forms of compensation, and selection for training including apprenticeship. The CCN further agrees to give public notice in conspicuous places available to employees and applicants for employment setting forth the provisions of this section. All solicitations or advertisements for employees shall state that all qualified applicants will receive consideration for employment without regard to handicap, age, race, color, religion, sex, or national origin. All inquiries made to the CCN concerning employment shall be answered without regard to handicap, age, race, color, religion, sex, or national origin. All responses to inquiries made to the CCN concerning employment made possible as a result of this Contract shall conform to federal, state, and local regulations.

19.18. Entire Contract

The CCN shall comply with all provisions of the Contract, including addenda, amendments and appendices, and shall act in good faith in the performance of the provisions of said Contract. The CCN shall be bound by all Department issued ***Guides*** related to the CCN. The CCN agrees that failure to comply with the provisions of the Contract may result in the assessment of monetary penalties, sanctions and/or termination of the Contract in whole or in part, as set forth in the Contract. The CCN shall comply with all applicable DHH manuals, policies and procedures in effect throughout the duration of the Contract period. The CCN shall comply with all rules and regulations. Where the provisions of the Contract differ from the requirements set forth in the guides, handbooks and/or manuals, the Contract provisions shall control.

DHH, at its discretion, will issue correspondence to inform the CCN of changes in policies and procedures which may affect the Contract. Unless otherwise specified in the Medicaid correspondence the CCN will be given sixty (60) calendar days to implement such changes.

19.19. Force Majeure

The CCN and DHH may be excused from performance under this Contract for any period they may be prevented from performance by an Act of God; strike, war, civil disturbance or court order. The CCN shall, however, be responsible for the development and implementation of an Emergency Management Plan as specified in §14.38 of this RFP.

19.20. Fraudulent Activity

19.20.1. The CCN shall report to DHH any cases of suspected Medicaid fraud or abuse by its members, network providers, employees, or subcontractors. The CCN shall report such suspected fraud or abuse in writing as soon as practical after discovering suspected incidents. The CCN shall report the following fraud and abuse information to DHH:

19.20.1.1. The number of complaints of fraud and abuse made to the CCN that warrant preliminary investigation; and

19.20.1.2. For each case of suspected provider fraud and abuse that warrants a full investigation:

- the provider's name and number,
- the source of the complaint,
- the type of provider,
- the nature of the complaint,
- the approximate range of dollars involved, and
- the legal and administrative disposition of the case.

19.20.2. The CCN shall adhere to the policy and process contained in the CCN Policy and Procedures Guide for referral of cases and coordination with the DHH's Program Integrity Unit for fraud and abuse complaints regarding members and providers.

19.21. **Governing Law and Place of Suit**

Louisiana Revised Statutes 39:1524 – 1526 provide a contract controversy procedure for state contracts. It is mutually understood and agreed that this Contract shall be governed by the laws of the State of Louisiana except its conflict of laws provision both as to interpretation and performance. Any action at law, suit in equity, or judicial proceeding for the enforcement of this Contract or any provision thereof shall be instituted only in the administrative tribunals and courts of the State of Louisiana. Specifically any state court suit shall be filed in the 19th Judicial District as the exclusive venue for same, and any federal suit shall be filed in the Middle District for the State of Louisiana as the exclusive venue for same. This section shall not be construed as providing a right / cause of action to the CCN in any of the aforementioned Courts.

19.22. **HIPAA**

19.22.1. **HIPAA Business Associate**

Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as agreed upon in HIPAA Business Associate Agreement. (See Appendix C)

19.22.2. **Compliance**

The CCN shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (the HITECH act) and the rules and regulations promulgated there under (45 CFR Parts 160, 162,

and 164). The CCN shall ensure compliance with all HIPAA requirements across all systems and services related to this Contract, including transaction, common identifier, and privacy and security standards, by the effective date of those rules and regulations.

19.23. Hold Harmless

19.23.1. The CCN shall indemnify, defend, protect, and hold harmless DHH and any of its officers, agents, and employees from:

19.23.1.1. Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies for the CCN in connection with the performance of this Contract;

19.23.1.2. Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or federal Medicaid regulations or legal statutes, by CCN, its agents, officers, employees, or subcontractors in the performance of this Contract;

19.23.1.3. Any claims for damages or losses resulting to any person or firm injured or damaged by the CCN, its agents, officers, employees, or subcontractors by CCN's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Contract in a manner not authorized by the Contract or by Federal or State regulations or statutes;

19.23.1.4. Any failure of the CCN, its agents, officers, employees, or subcontractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;

19.23.1.5. Any claims for damages, losses, or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of DHH in connection with the defense of claims for such injuries, losses, claims, or damages specified above;

19.23.1.6. Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHH or its agents, officers or employees, through the intentional conduct, negligence or omission of the CCN, its agents, officers, employees or subcontractors.

19.23.2. In the event that, due to circumstances not reasonably within the control of CCN or DHH, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither the CCN, DHH, or subcontractor(s), will have any liability or obligation on account of reasonable delay in the provision or the arrangement of core benefits and services; provided, however, that so long as this Contract remains in full force and effect, the CCN shall be liable for the core benefits and services required to be provided or arranged for in accordance with this Contract.

19.23.3. DHH will provide prompt notice of any claim against it that is subject to indemnification by CCN under this Contract. The CCN may, at its sole option, assume the defense of any such claim. DHH may not settle any claim subject to indemnification hereunder without the advance written consent of CCN, which shall not be unreasonably withheld.

19.24. <u>Hold Harmless as to the CCN Members</u>

19.24.1. The CCN hereby agrees not to bill, charge, collect a deposit from, seek cost sharing or other forms of compensation, remuneration or reimbursement from, or have recourse against, CCN members, or persons acting on their behalf, for health care services which are rendered to such members by the CCN and its subcontractors, and which are core benefits and services under the Contract.

19.24.2. The CCN further agrees that the CCN member shall not be held liable for payment for core benefits and services furnished under a provider subcontract, referral, or other arrangement, to the extent that those payments would be in excess of the amount that the member would owe if the CCN provided the service directly. The CCN agrees that this provision is

applicable in all circumstances including, but not limited to, non-payment by CCN and insolvency of CCN.

19.24.3. The CCN further agrees that this provision shall be construed to be for the benefit of CCN members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the CCN and such members, or persons acting on their behalf.

19.25. Homeland Security Considerations

The CCN shall perform the services to be provided under this Contract entirely within the boundaries of the United States. In addition, the CCN will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

If the CCN performs services, or uses services, in violation of the foregoing paragraph, the CCN shall be in material breach of this Contract and shall be liable to DHH for any costs, fees, damages, claims, or expenses it may incur. Additionally, the CCN shall be required to hold harmless and indemnify DHH pursuant to the indemnification provisions of this Contract.

The prohibitions in this Section shall also apply to any and all agents and subcontractors used by the CCN to perform any services under this Contract.

19.26. Incorporation of Schedules/Appendices

All schedules/appendices referred to in this RFP are expressly made a part hereof, and are incorporated as if fully set forth herein.

19.27. Independent Provider

It is expressly agreed that the CCN and any subcontractors and agents, officers, and employees of the CCN or any subcontractors in the performance of this Contract shall act in an independent capacity and not as officers, agents, express or implied, or employees of DHH or the State of Louisiana. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the CCN or any subcontractor and DHH and the State of Louisiana.

19.28. Integration

This Contract and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. The CCN also agrees to be bound by the department issued Guides and any rules or regulations that may be promulgated. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or affect whatsoever unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a written amendment executed and approved by the parties.

19.29. Interest

Interest generated through investments made by the CCN under this Contract shall be the property of the CCN and shall be used at the CCN's discretion.

19.30. Interpretation Dispute Resolution Procedure

The CCN may request in writing an interpretation of the issues relating to the Contract from the Medicaid CCN Program Director. In the event the CCN disputes the interpretation by the Medicaid CCN Program Director, the CCN shall submit a written reconsideration request to the Medicaid Director.

19.30.1. The CCN shall submit, within-twenty-one (21) days of said interpretation disputing the interpretation. The ability to dispute an interpretation does not apply to language in the Contract that is based on federal or state statute, regulation or case law.

19.30.2. The Medicaid Director shall reduce his decision to writing and provide a copy to the CCN. The written decision of the Medicaid Director shall be the final decision of DHH. The Medicaid Director will render this final decision based upon the written submission of the CCN and the Medicaid CCN Program Director, unless, at the sole discretion of the Medicaid Director, the Medicaid Director allows an oral presentation by the CCN and the Medicaid CCN Program Director or his/her designee. If such a presentation is allowed, the information presented will be considered in rendering the decision.

19.30.3. Pending final determination of any dispute over a DHH decision, the CCN shall proceed diligently with the performance of the Contract and in accordance with the direction of DHH.

19.31. Legal Services

No attorney-at-law shall be engaged through use of any direct funds provided by DHH pursuant to the terms of this Contract. Further, with the exception of attorney's fees specifically authorized by state or federal law, DHH shall under no circumstances become obligated to pay an attorney's fee or the costs of legal action to the CCN. This covenant and condition shall apply to any and all suits, legal actions, and judicial appeals of whatever kind or nature to which the CCN is a party.

19.32. Loss of Federal Financial Participation (FFP)

The CCN hereby agrees to be liable for any loss of FFP suffered by DHH due to the CCN's, or its subcontractors', failure to perform the services as required under this Contract. Payments provided for under this Contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR §438.730.

19.33. Misuse of Symbols, Emblems, or Names in Reference to Medicaid

No person or CCN may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast, or other production, alone or with other words, letters, symbols or emblems the words “Medicaid,” or “Department of Health and Hospitals” or “Bureau of Health Services Financing”,” unless prior written approval is obtained from DHH. Specific written authorization from DHH is required to reproduce, reprint, or distribute any DHH form, application, or publication for a fee. State and local governments are exempt from this prohibition. A disclaimer that accompanies the inappropriate use of program or DHH terms does not provide a defense. Each piece of mail or information constitutes a violation.

19.34. National Provider Identifier

19.34.1. The HIPAA Standard Unique Health Identifier regulations (45 CFR §162 Subparts A & D) require that all covered entities (health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES).

19.34.2. Pursuant to the HIPAA Standard Unique Health Identifier regulations (45 CFR §162 Subparts A & D), and if the provider is a covered health care provider as defined in 45 CFR §162.402, the provider agrees to disclose its National Provider Identifier (NPI) to DHH once obtained from the NPPES. CCN also agrees to use NPI identifier on all standard transactions that it conducts with DHH.

19.35. Non-Assignability

No assignment or transfer of this Contract or of any rights hereunder by the CCN shall be valid without the prior written consent of DHH and DOA.

19.36. Non-Discrimination

In accordance with 42 CFR 438.6 (d) (3) and (4), the CCN shall not discriminate in the enrollment of Medicaid individuals into the CCN. The CCN agrees that no person, on the grounds of handicap, age, race, color, religion, sex, national origin, or basis of health status or need for health care services shall be excluded from participation in, or be denied benefits of the CCN's program or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the CCN. The CCN shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all provider contracts.

19.37. Non-Waiver of Breach

19.37.1. The failure of DHH at any time to require performance by the CCN of any provision of this Contract, or the continued payment of the CCN by DHH, shall in no way affect the right of DHH to enforce any provision of this Contract; nor shall the

waiver of any breach of any provision thereof be taken or held to be a waiver of any succeeding breach of such provision or as a waiver of the provision itself. No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract shall be waived except by the written agreement of the parties and approval of CMS, if applicable.

19.37.2. Waiver of any breach of any term or condition in this Contract shall not be deemed a waiver of any prior or subsequent breach. No term or condition of this Contract shall be held to be waived, modified, or deleted except by an instrument, in writing, signed by the parties hereto.

19.38. Offer of Gratuities

By signing this Contract, the CCN signifies that no member of, or a delegate of, Congress, nor any elected or appointed official or employee of the State of Louisiana, the Government Accountability Office, DHHS, CMS, or any other federal agency has or shall benefit financially or materially from this Contract. This Contract may be terminated by DHH if it is determined that gratuities of any kind were offered to, or received by, any officials or employees from the state, its agents, or employees.

19.39. Order of Precedence

In the event of any inconsistency or conflict among the document elements of this Contract, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

19.39.1. The body of the Contract excluding the RFP and the proposal

19.39.2. This RFP and any appendices

19.39.3. CCN-P Systems Companion Guide

19.39.4. CCN Quality Companion Guide

19.39.5. The proposal submitted by the CCN in response to this RFP

19.40. Political Activity

None of the funds, materials, property, or services provided directly or indirectly under this Contract shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the "Hatch Act".

19.41. Release of Records

The CCN shall release medical records of members as may be authorized by the member, as may be directed by authorized personnel of DHH, appropriate agencies of the State of Louisiana, or the United States Government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in this Contract. The ownership and procedure for release of medical records shall be controlled by the Louisiana revised statutes, including but not limited to, La.R.S. 40:1299.96, La.R.S. 13:3734, and La.C.Ev. Art. 510; and the 45 CFR Parts 160 and 164(HIPAA Privacy Rule).

19.42. Safeguarding Information

The CCN shall establish written safeguards which restrict the use and disclosure of information concerning members or potential members to purposes directly connected with the performance of this Contract. The CCN's written safeguards shall:

19.42.1. Be comparable to those imposed upon the DHH by 42 CFR Part 431, Subpart F (2005, as amended) and La R.S. 45:56;

19.42.2. State that the CCN will identify and comply with any stricter state or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;

19.42.3. Require a written authorization from the member or potential member before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 CFR §164.508;

19.42.4. Not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

19.42.5. Specify appropriate personnel actions to sanction violators.

19.43. Safety Precautions

DHH and HHS assume no responsibility with respect to accidents, illnesses or claims arising out of any activity performed under this Contract. The CCN shall take necessary steps to ensure or protect its members, itself, and its personnel. The CCN agrees to comply with all applicable local, state, and federal occupational and safety acts, rules, and regulations.

19.44. Severability

If any provision of this Contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both DHH and CCN shall be relieved of all obligations arising under such provision. If the remainder of this Contract is capable of performance, it shall not be affected by such declaration or finding and shall be fully performed. In addition, if the laws or regulations governing this Contract should be amended or judicially interpreted as to render the fulfillment of the Contract impossible or economically infeasible, both DHH and the CCN will be discharged from further obligations created under the terms of the Contract.

19.45. Software Reporting Requirement

All reports submitted to DHH by the CCN must be in format accessible and modifiable by the standard Microsoft Office Suite of products, version 2003 or later, or in a format accepted and approved by DHH.

19.46. Subsequent Conditions

The CCN shall comply with all requirements of this RFP and DHH shall have no obligation to enroll any CCN Program Members into the CCN until such time as said requirements have been met.

19.47. Termination for Convenience

DHH may terminate this Contract for convenience and without cause upon sixty (60) calendar days written notice. DHH shall not be responsible to the CCN or any other party for any costs, expenses, or damages occasioned by said termination, i.e., the termination by DHH shall be without penalty. The CCN shall be responsible to adhere to the requirements specified in Turnover Plan (See Appendix JJ).

19.48. Termination for Unavailability of Funds

19.48.1. In the event that federal and/or state funds to finance this Contract become unavailable after the effective date of this Contract, or prior to the anticipated Contract expiration date, DHH may terminate the Contract without penalty. This notification will be made in writing. Availability of funds shall be determined solely by DHH.

19.48.2. The CCN shall comply with all requirements specified in Appendix JJ – Turnover Plan and the termination requirements in this RFP.

19.49. Titles

All titles used herein are for the purpose of clarification and shall not be construed to infer a contractual construction of language.

19.50. Use of Data

DHH shall have unlimited rights to use, disclose, or duplicate, for any purpose, all information and data developed, derived, documented, or furnished by the CCN resulting from this Contract.

19.51. Warranty to Comply with State and Federal Regulations

The CCN shall warrant that it shall comply with all state and federal regulations as they exist at the time of the Contract or as subsequently amended.

19.52. Warranty of Removal of Conflict of Interest

The CCN shall warrant that it, its officers, and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services hereunder. The CCN shall periodically inquire of its officers and employees concerning such conflicts, and shall inform DHH promptly of any potential conflict. The CCN shall warrant that it shall remove any conflict of interest prior to signing the Contract.

19.53. Waiver

The waiver by DHH of any breach of any provision contained in this Contract shall not be deemed to be a waiver of such provision on any subsequent breach of the same or any other provision contained in this Contract and shall not establish a course of performance between the parties contradictory to the terms hereof.

19.54. Time Is Of The Essence

Time is of the essence in this Contract. Any reference to "days" shall be deemed calendar days unless otherwise specifically stated.

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20. PROPOSAL AND EVALUATION

20.1. General Information

This section outlines the provisions which govern determination of compliance of each proposer's response to the RFP. DHH shall determine, at its sole discretion, whether or not the requirements have been reasonably met. Omissions of required information shall be grounds for rejection of the proposal by DHH.

Proposers are responsible for determining that there will be no conflict or violation of the Ethics Code if their company is awarded the contract. The Louisiana Board of Ethics is they only entity which can officially rule on ethics issues.

20.2. Contact After Solicitation Deadline

After the date for receipt of proposals, no proposer-initiated contact relative to the solicitation will be allowed between the proposers and DHH until an award is made.

20.3. Rejection and Cancellation

Issuance of this solicitation does not constitute a commitment by DHH to award a contract or contracts. DHH reserves the right to reject any or all proposals received in response to this solicitation.

In accordance with the provisions of R.S. 39:2182, in awarding contracts after August 15, 2010,any public entity is authorized to reject a proposal or bid from, or not award the contract to, a business in which any individual with an ownership interest of five percent or more, has been convicted of, or has entered a plea of guilty or *nolo contendere* to any state felony or equivalent federal felony crime committed in the solicitation or execution of a contract or bid awarded under the laws governing public contracts under the provisions of Chapter 10 of Title 38 of the Louisiana Revised Statutes of 1950, professional, personal, consulting, and social services procurement under the provisions of Chapter 16 of this Title, or the Louisiana Procurement Code under the provisions of Chapter 17 of this Title.

20.4. Award Without Discussion

The Secretary of DHH reserves the right to make an award without presentations by proposers or further discussion of proposals received.

20.5. Assignments

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

20.6. Proposal Cost

The proposer assumes sole responsibility for any and all costs associated with the preparation and reproduction of any proposal submitted in response to this RFP.

20.7. Ownership of Proposal

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

20.8. Procurement Library/Resources Available to Proposer

20.8.1. Electronic copies of material relevant to this RFP will be posted at the following web addresses:

http://new.dhh.louisiana.gov/index.cfm/newsroom/category/47 and
http://wwwprd.doa.louisiana.gov/OSP/LaPAC/bidlist.asp?department=4, and
http://www.makingmedicaidbetter.com

20.8.2. Potential proposers may receive historic Medicaid de-identified claims data in SAS7BDAT format at the parish of residence level for SFY 09 and SFY 10, for CCN core benefits and services as well as pharmacy data, for mandatory and voluntary CCN populations under the following conditions:

20.8.2.1. Submit the non-binding Letter of Intent to Propose to the RFP Coordinator;

20.8.2.2. Sign and submit the CCN Data Sharing Agreement (Appendix LL) to the RFP Coordinator; and

20.8.2.3. Provide a computer hard drive or flash drive with a capacity of at least 16GB on which to load the data, along with the name of the person who will be picking up the data or the name and address to which the data is to be mailed to the following address:

Medicaid Coordinated Care Section
Attn: Ruth Kennedy, RFP Coordinator
628 North 4th Street, 6th Floor
Baton Rouge, LA 70821

20.8.3. Medicaid program manuals and pertinent Federal and State regulations, as well as other materials will be available in electronic format, are available for review upon request in the Procurement Library. The library is located at

Department of Health & Hospitals, Bienville Building
628 North 4th Street
Baton Rouge, LA. 70802

Arrangements may be made through the RFP Coordinator for access to the library. The library will be open by appointment only during the hours of 8:30 am CT to 4:00 pm CT on Monday through Friday beginning the day after public notice of the RFP and ending on the day before proposals are due.

20.9. Proposal Submission

All proposals must be received by the due date and time indicated on the Schedule of Events. Proposals received after the due date and time will not be considered. It is the sole responsibility of each proposer to assure that its proposal is delivered at the specified location prior to the deadline. Proposals which, for any reason, are not so delivered will not be considered.

20.9.1. Proposer shall submit one (1) original hard copy and should submit one electronic copy and ten (10) hard copies of each proposal. No

facsimile or emailed proposals will be accepted. The cost proposal and financial statements should be submitted separately from the technical proposal; however, for mailing purposes, all packages may be shipped in one container.

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

If courier mail or hand delivered:
Mary Gonzalez
Department of Health and Hospitals
Division of Contracts and Procurement Support
628 N 4th Street 5th Floor
Baton Rouge, LA 70802

If delivered via US Mail:
Mary Gonzalez
Department of Health and Hospitals
Division of Contracts and Procurement Support
P.O. Box 1526
Baton Rouge, LA 70821-1526

20.9.3. Proposal Prohibitions

Proposer shall not submit multiple proposals for the same model CCN in different forms. This prohibited action shall be defined as a Proposer submitting one proposal as a prime contractor and permitting a second Proposer to submit another proposal with the first Proposer offered as a subcontractor for the same model CCN (CCN–S or CCN-P). This restriction does not prohibit different Proposers from offering the same subcontractor as a part of their proposals, provided that the subcontractor does not also submit a proposal as a prime contractor and the subcontractor has the capacity to provide services as a subcontractor to two prime contractors.

20.9.4. Waiver of Minor Proposal Errors

DHH may, at its sole discretion, waive minor errors or omissions in proposals/forms when those errors do not obscure the meaning of the content.

20.9.5. Proposal Clarifications

DHH reserves the right to request clarifications from proposers of any information in their proposals/forms, and may request such clarification as it deems necessary at any point in the proposal review process.

20.9.6. Interpretive Conventions

20.9.6.1. Whenever the terms "must," or "is required" are used in this RFP in conjunction with a specification or performance requirement, the specification or requirement is mandatory. A proposer's failure to address or meet any mandatory requirement in a proposal may be cause for DHH's rejection of the proposal.

20.9.6.2. Whenever the terms "can," "may," or "should" are used in this RFP in conjunction with a specification or performance requirement, the specification or performance requirement is a desirable, but not mandatory, requirement. Accordingly, a Respondent's failure to address or provide any items so referred to will not be the cause for rejection of the proposal, but will likely result in a less favorable evaluation.

20.10. <u>Proprietary and/or Confidential Information</u>

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

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

protections must be claimed by the proposer at the time of submission of its Technical Proposal. Proposers should refer to the Louisiana Public Records Act for further clarification.

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

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

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

Proposers must be prepared to defend the reasons why the material should be held confidential. If a competing proposer or other person seeks review or copies of another proposer's confidential data, DHH will notify the owner of the asserted data of the request. If the owner of the asserted data does not want the information disclosed, it must take legal action as necessary to restrain DHH from releasing information DHH believes to be public record.

If the proposal contains confidential information, a redacted copy of the proposal must be submitted. If a redacted copy is not submitted, DHH may consider the entire proposal to be public record. When submitting the redacted copy, it should be clearly marked on the cover as - "REDACTED COPY". The redacted copy should also state which sections or information has been removed."

Any proposal marked as confidential or proprietary in its entirety may be rejected without further consideration or recourse.

20.11. Proposal Format

20.11.1. Each proposal should be economically prepared, with emphasis on completeness and clarity of content. A proposal, as well as any reference material presented, must be written in English and must be typed on standard 8 1/2" x 11" paper with recommended margins of one inch. It should be single spaced with text no smaller than 11-point font; pages may be single sided or double sided. All proposal pages should be numbered and identified with the Proposer's name. Material should be sequentially filed in three ring binders no larger than three inches in thickness.

20.11.2. The RFP and CCN-S Proposal Submission and Evaluation Requirements (Appendix BB) details the specific requirements for making a Proposal in response to this RFP, including a Proposal for Geographic Service Area "A" or "B" or "C" or any combination of the three GSAs. The Requirements include mandatory and general technical requirements as well as queries requiring a written response.

20.11.3. All information included in a Proposal should be relevant to a specific requirement detailed in the CCN-S Proposal Submission and Evaluation Requirements (Appendix BB) and as specified in the RFP. All information should be incorporated into a response to a specific requirement and clearly referenced. For each response the Proposer should include both the section and number of the requirement, the GSA (s) to which the response is applicable and the text of the requirement from the CCN-S Proposal Submission and Evaluation Requirements Appendix BB.

20.11.4. The cover of the Proposal should clearly indicate whether the Proposal is for Geographic Service Area (GSA) "A" (DHH Regions 1and 9), Geographic Service Area (GSA) "B" (DHH Regions 2, 3 and 4), Geographic Service Area "C" (DHH Regions 5, 6, 7, and 8) or if for multiple GSA's, specify the names of all GSAs for which the Proposal is being submitted.

20.11.5. The response to the Mandatory Requirements Section (Section A) should be in a separate binder and clearly labeled with contents. The Proposer should duplicate the

CCN-P Proposal Submission and Evaluation Requirements, Section A and use as the Table of Contents. The response to each subsection (A-1, A-2, A-3, etc) should be clearly tabbed. If the Proposal is for multiple GSAs and the responses differ for one or more GSA, the proposer should clearly indicate the GSA(s) for which each response is applicable.

20.11.6. The response to the Technical Requirements Sections (Sections B-F) should be in separate binder (s) and clearly labeled with contents. The Proposer should duplicate the CCN-S Proposal Submission and Evaluation Requirements, Section B-F and use as the Table of Contents. The response to each subsection (B, C, D, E, F) should be clearly tabbed and labeled. If the Proposal is for multiple GSAs and the responses differ for one or more GSA, the proposer should clearly indicate the GSA(s) for which each response is applicable.

20.11.7. Attachments should only be provided as requested in the CCN-S Proposal Submission and Evaluation Requirements and should be clearly labeled, including the Section and number from the Requirements. Any information not meeting these criteria will be deemed extraneous and will in no way contribute to the evaluation process.

20.12. <u>Proposal Content</u>

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

20.12.2. Proposals should address how the proposer intends to assume complete responsibility for timely performance of all contractual responsibilities in accordance with federal and state laws, regulations, policies, and procedures.

20.12.3. Proposals should define proposer's functional approach in providing services and identify the tasks necessary to meet

the RFP requirements of the provision of services, as outlined in the RFP.

20.12.4. The Proposer may not submit the Proposer's own contract terms and conditions or other requirements in a response to this RFP.

20.13. Evaluation Categories and Maximum Points

The following criteria will be used to evaluate proposals:

Section	Category	Total Possible Points
A	Mandatory Requirements	0
B	Qualifications and Experience	340
C	Planned Approach to Project	100
D	Member Enrollment and Disenrollment	25
E	Chronic Care/Disease Management	100
F	Service Coordination	160
G	Provider Network	110
H	Utilization Management	80
I	EPSDT	25
J	Quality Management	115
K	Member Materials	50
L	Customer Service	100
M	Emergency Management Plan	25
N	Grievance and Appeals	25
O	Fraud and Abuse	15
P	Claims Management	80
Q	Information Systems	200
R	Added Value to Louisiana	100
	TOTAL	**1,650**

20.13.1. All proposals will be reviewed and scored for each Section by a Proposal Review Team (PRT), comprised of three or more DHH employees.

20.13.2. Proposal Review Team members will be required to sign disclosure forms to establish that they have no personal or financial interest in the outcome of the proposal review and contractor selection process.

20.13.3. Evaluations of the financial statements will be conducted by a member of the DHH Fiscal Division and other appropriate staff.

20.13.4. Each Proposal Evaluation Team member shall evaluate each proposal against the evaluation criteria in this RFP, rather than against other proposals, and scoring will be done by consensus of the PRT assigned to each Section.

20.13.5. Proposals containing assumptions, lack of sufficient detail, poor organization, lack of proofreading and unnecessary use of self-promotional claims will be evaluated accordingly.

20.13.6. DHH reserves the right, at its sole discretion, to request Proposer clarification of a Proposal provision or section or to conduct clarification discussions with any or all Proposers. Any such clarification or discussion shall be limited to specific sections of the proposal identified by DHH. The subject Proposer shall put any resulting clarification in writing as may be required by DHH.

20.13.7. Scoring will be based on a possible total of 1,650 points, and the three (3) proposals with the highest total scores in each GSA may be recommended for award.

20.14. Announcement of Award

DHH will recommend contract awards to the three proposers with the highest graded proposals in each GSA and that are deemed to be in the best interest of DHH. DHH reserves the right to not award contracts for any proposal scoring less than 1,320 points. DHH reserves the right not to award a Contract or award fewer than three (3) contracts.

20.15. Notice of Contract Award

The notice of intended contract award shall be sent in writing to the winning proposers. No proposer shall infer or be construed to have any rights or interest to a contract with DHH until both the proposer and DHH have executed a valid contract and final approval is received from all necessary entities.

21 GLOSSARY

The following terms, as used in this RFP, shall be construed and interpreted as follows unless the context clearly requires otherwise.

Abuse –Related to Medicaid Program Integrity, in accordance with 42 CFR §455.2, abuse means provider practices 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 for health care. Recipient practices that result in unnecessary cost to the Medicaid program are also included.

Action -– The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the state; the failure of a CCN to act within the timeframes provided in §438.408(b); or for a resident of a rural area with only one CCN, the denial of a Medicaid enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network..

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

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health Care. It also includes member practices that result in unnecessary cost to the Medicaid program.

Actuarially Sound PMPM rates - PMPM rates that (1) have been developed in accordance with generally accepted actuarial principles and practices; (2) are appropriate for the populations to be covered, and the services to be furnished under the contract; and (3) have been certified, as meeting the requirements of this definition, by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

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

Adequate Network/Adequacy of Network – Refers to the network of health care providers for a CCN that is sufficient in numbers and types of providers and facilities to ensure that all services are accessible to members without unreasonable delay. Adequacy is determined by a number of factors, including but not limited to, provider-

patient ratios for primary care providers; geographic accessibility and travel distance; waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider)for appointments and hours of provider operations.

Adjudicate - means to deny or pay a Clean Claim.

Adverse Action – Any decision by the CCN to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested in accordance with 42 CFR § 438.214(c)

Adverse Determination - An admission, availability of care, continued stay or other health care service that has been reviewed by a CCN entity and based upon the information provided, does not meet the CCN's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced, suspended, delayed or terminated.

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

(1) owns or holds more than a five percent (5%) interest in the CCN (either directly, or through one (1) or more intermediaries); (2) in which the CCN owns or holds more than a five percent (5%) interest (either directly, or through one (1) or more intermediaries);

(3) any parent entity or subsidiary entity of the CCN regardless of the organizational structure of the entity; (4) any entity that has a common parent with the CCN (either directly, or through one (1) or more intermediaries); (5) any entity that directly, or indirectly through one (1) or more intermediaries, controls, or is controlled by, or is under common control with, the CCN; or (6) any entity that would be considered to be an affiliate by any Securities and Exchange Commission (SEC) or Internal Revenue Service (IRS) regulation, Federal Acquisition Regulations (FAR), or by another applicable regulatory body.

Age Discrimination Act of 1975 - prohibits discrimination on the basis of age in programs and activities receiving federal financial assistance. The Act, which applies to all ages, permits the use of certain age distinctions and factors other than age that meet the Act's requirements. The Age Discrimination Act is enforced by the Office for Civil Rights.

Aged/Blind/Disabled A unique eligibility category within the Medicaid Program that defines specific conditions for which a person may be determined eligible to receive Medicaid health care services. Applies to individuals who are eligible for Medicaid due to blindness or disability.

Agent - An entity that contracts with DHH to perform administrative functions, including but not limited to fiscal intermediary activities, outreach, eligibility, and enrollment activities, systems and technical support, etc.

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

Americans with Disabilities Act of 1990 (ADA) – The Americans with Disabilities act prohibits discrimination against people with disabilities in employment, transportation, public accommodation, communications and governmental activities. The ADA also establishes requirements for telecommunications relay services.

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

Appeal – A request for a review of an action pursuant to 42 CFR § 438.400(b).

Appeal Procedure - A formal process whereby a member has the right to contest an adverse determination/action rendered by a CCN entity, which results in the denial, reduction, suspension, termination or delay of health care benefits/services. The appeal procedure shall be governed by Louisiana Medicaid rules and regulations and any and all applicable court orders and consent decrees.

Automatic Assignment – The process utilized to enroll into a CNN, using predetermined algorithms, a Medicaid eligible that 1) is not excluded from CCN participation and 2) does not proactively select a CCN within the DHH specified timeframe.

Behavioral Health Services (BHS) – Mental health and substance abuse services, which are provided to enrollees with emotional, psychological, substance abuse, psychiatric symptoms and/or disorders. Basic behavioral health services are provided in the enrollee's PCP office by the enrollee's PCP as part of primary care service activities as well as those services provided in an FQHC. Specialized mental health services shall include, but not be limited to, services specifically defined in state plan and provided by a psychiatrist, psychologist, and/or mental health rehabilitation provider to those enrollees with a primary diagnosis of a behavioral disorder.

Benefits or Covered Services - Those health care services to which an eligible Medicaid recipient is entitled under Louisiana Medicaid State Plan.

Blocked Call - A call that cannot be connected immediately because no circuit is available at the time the call arrives or the telephone system is programmed to block calls from entering the queue when the queue backs up beyond a defined threshold.

Board Certified - An individual who has successfully completed all prerequisites of a respective medical specialty board and has successfully passed the required examination for certification.

Bureau of Health Services Financing (BHSF) — The agency within the Louisiana Department of Health & Hospitals, Office of Management & Finance that has been designated as Louisiana's single state Medicaid agency to administer the Medicaid and CHIP programs.

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

Business Day – Traditional workdays, including Monday, Tuesday, Wednesday, Thursday and Friday and the traditional work hours are 8 a.m. to 5 p.m. (Central Standard Time). State holidays are excluded. For a list of Louisiana state holidays, see the following website:
http://www.civilservice.la.gov/OtherInfo/StateEmployeesInfo/bene%20HOLIDAYS.asp

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

Calendar Days — All seven (7) days of the week. Unless otherwise specified, the term "days" in this RFP refers to calendar days.

Care Coordination – Deliberate organization of patient care activities by a person or entity formally designated as primarily responsible for coordinating services furnished by providers involved in the member's care to facilitate care within the network with services provided by non-network providers to ensure appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of member's care.

Care Management - Overall system of medical management encompassing Utilization Management, Referral, Case Management, Care Coordination, Continuity of Care and Transition Care, Chronic Care Management, Quality Care Management, and Independent Review.

Case Management – Refers to a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a member's needs through

communication and available resources to promote high quality, cost-effective outcomes. Case management services are defined as services provided by qualified staff to a targeted population to assist them in gaining timely access to the full range of needed services including medical, social, educational, and other support services. Case Management services include an individual needs assessment and diagnostic assessment, individual treatment plan development, establishment of treatment objectives, and monitoring outcomes.

Case Manager - A person who is either a degreed social worker, licensed registered nurse, or a person with a minimum of two years experience in providing case management services to persons who are elderly and/or persons with physical or developmental disabilities. Case management manager shall not provide direct care services to members enrolled with the Contractor, but shall authorize appropriate services and/or refer members to appropriate services.

Cause — Specified reasons that allow mandatorily enrolled CCN members to change their CCN choice. Term may also be referred to as "good cause."

CCN-S Systems Companion Guide – A supplement to the contract that outlines the formatting and reporting requirements concerning claims, interfaces between the FI and the CCN and enrollment broker and the CCN.

Centers for Disease Control/Advisory Committee on Immunization Practices (CDC/ACIP) Federal agency and committee whose role is to provide advice that will lead to a reduction in the incidence of vaccine-preventable diseases in the United States and an increase in the safe use of vaccines and related biological products.

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

Certified Nurse Midwife (CNM) – An advanced practice registered nurse educated in the disciplines of nursing and midwifery and certified according to a nationally recognized certifying body, such as the American College of Nurse Midwives Certification Council, as approved by the state board of nursing and who is authorized to manage the nurse midwifery care of newborns and women in the ante-partum, intra-partum, postpartum, and/or gynecological periods.

CFR - Code of Federal Regulations.

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

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

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

Chronic Condition - A condition that lasts more than one year, limits a person's activities, and may require ongoing medical care.

Chronic Care Management Program (CCMP) - A system of coordinated health care in which interventions and communications for populations with conditions in which patient self-care efforts are significant. Chronic care management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Chronic Care Management - The concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care.

Claim – means 1) a bill for services; 2) a line item of service or 3) all services for one recipient within a bill. A request for payment for benefits received or services rendered.

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

CMS 1500 - Universal claim form, required by CMS, to be used by non-institutional and institutional providers that do not use the UB-92.

CCN Administrative Services - The performance of services or functions, other than the direct delivery of covered services, necessary for the management of the delivery of and payment for covered services, including but not limited to network, utilization, clinical and/or quality management, service authorization, claims processing, management information systems operation, and reporting.

Cold Call Marketing – Any unsolicited personal contact with a Medicaid eligible individual by the CCN, its staff, its volunteers or its vendors/subcontractors with the

purpose of influencing the Medicaid eligible individual to enroll in the CCN or either to not enroll in or disenroll from another CCN.

CommunityCARE 2.0– Refers to the Louisiana Medicaid Primary Care Case Management (PCCM) program which links Medicaid eligibles to a primary care provider as their medical home.

Contract or Agreement –. The written agreement between DHH and the CCN; comprised of the RFP, Contract, any addenda, appendices, attachments, or amendments thereto.

Contract Dispute - A circumstance whereby the CCN and their subcontractor are unable to arrive at a mutual interpretation of the requirements, limitations, or compensation for the performance of services under their subcontract.

Convicted – A judgment of conviction entered by a federal, state or local court, regardless of whether an appeal from that judgment is pending.

Coordinated Care Network - Prepaid (CCN-P) – The private entity that contracts with DHH to provide core benefits and services to Louisiana Medicaid CCN Program enrollees in exchange for a monthly prepaid capitated amount per member. The entity is regulated by the Louisiana Department of Insurance with respect to licensure and financial solvency, pursuant to Title 22:1016 of the Louisiana Revised Statues, but shall, solely with respect to its products and services offered pursuant to the Louisiana Medicaid Program be regulated by the Louisiana Department of Health and Hospitals.

Coordinated Care Network – Shared Savings (CCN-S) – An entity that serves as a primary care case manager by providing enhanced primary care case management in addition to contracting with primary care providers (PCPs) for primary care management.

Coordinated Care Program – Louisiana Medicaid program providing statewide leadership to most effectively utilize resources to promote the health and well being of Louisianans in DHH's Shared Savings Coordinated Care Network and Prepaid Coordinated Care Network programs..

Co-payment - Any cost sharing payment for which the Medicaid CCN member is responsible, in accordance with 42 CFR, § 447.50 and Section 5006 of the American Recovery and Reinvestment Act (ARRA) for Native American members.

Core Benefits and Services - Enhanced primary care case management services required to be provided by the CCN-S to Medicaid CCN members as specified under the terms and conditions of this RFP.

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

Cost-Based Reimbursement - A method of payment of medical care by third parties for services delivered to patients. The amount of payment is based on the allowable costs to the provider for delivering the service.

Covered Services - Those health care services and benefits to which an individual eligible for Medicaid or CHIP is entitled under the Louisiana Medicaid State Plan.

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

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

Deliverable - A document, manual or report submitted to DHH by the CCN to fulfill requirements of this Contract.

Denied Claim - A claim for which no payment is made to the network provider by the CCN for any of several reasons, including but not limited to, the claim is for non-covered services, an ineligible provider or recipient, or is a duplicate of another transaction, or has failed to pass a significant requirement in the claims processing system.

Department (DHH) – The Louisiana Department of Health and Hospitals, referred to as DHH throughout this RFP.

DHH Administrative Regions – The nine Louisiana geographic areas designated in state statute for administrative purposes. Each geographic area is comprised of specific parishes. For specific areas see:
http://www.dhh.louisiana.gov/offices/medialibrary/media-1/REG_MAP04.jpg

Disease Management (DM) – see Chronic Care Management

Disenrollment - The removal of a member from participation in the CCNs plan, but not necessarily from the Medicaid or LaCHIP program.

Documented Attempt - A *bona fide*, or good faith, attempt, in writing, by the CCN to contract with a provider, made on or after the date the CCN signs the Contract with DHH. Such attempts may include written correspondence that outlines contract negotiations between the parties, including rate and contract terms disclosure. If, within 10 calendar days, the potential network provider rejects the request or fails to respond either verbally or in writing, the CCN may consider the request for inclusion in the CCN's network denied by the provider. This shall constitute one attempt.

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

Durable Medical Equipment , Prosthetics, Orthotics, and certain Supplies (DMEPOS) – DME is inclusive of equipment which 1) can withstand repeated use, 2) is primarily and customarily used to serve a medical purpose; 3) generally is not useful to a person in the absence of illness or injury, and 4) is appropriate for use in the home. POS is inclusive of prosthetics, orthotics and certain supplies. Certain supplies are those medical supplies that are of an expendable in nature, such as catheters and diapers.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) - A federally required Medicaid benefit for individuals under the age of 21 years that expands coverage for children and adolescents beyond adult limits to ensure availability of 1) screening and diagnostic services to determine physical or mental defects and 2) health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (CFR 440.40 (b)). EPSDT requirements help to ensure access to all medically necessary health services within the federal definition of "medical assistance".

E-Consultation - The use of electronic computing and communication technologies in consultation processes.

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

Eligibility Determination - The process for which an individual may be determined eligible for the Medicaid or Medicaid-expansion CHIP program.

Eligible - An individual determined eligible for assistance in accordance with the Medicaid State Plan(s) under the Title XIX (Medicaid) or Title XXI (CHIP) of the Social Security Act.

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

Emergency Services – Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 CFR 438.114(a) and 1932(b)(2) and that are needed to screen, evaluate or stabilize an emergency medical condition.

Enrollee – Louisiana Medicaid or CHIP recipient who is currently enrolled in a CCN or other Medicaid managed care program.

Enrollment - The process conducted by the Enrollment Broker by which an eligible Medicaid recipient becomes a member of a CCN.

Enrollment Broker – The state's contracted or designated agent that performs functions related to choice counseling, enrollment and disenrollment of potential enrollees into a CCN.

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

Excluded Populations - Medicaid eligibles that are excluded from enrollment in a CCN and may not voluntarily enroll.

Excluded Services - those services which members may obtain under the Louisiana Medicaid State Plan and for which the CCN is not financially responsible.

Expanded Services - A covered service provided by the CCN which is currently a non-covered service(s) in the Medicaid State Plan or is an additional Medicaid covered service furnished by the CCN to Medicaid CCN members for which the CCN receives no additional capitated payment, and is offered to members in accordance with the standards and other requirements set forth in the RFP.

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

External Quality Review (EQR) - The analysis and evaluation by an external quality review organization of aggregated information on quality, timeliness, and access to the health care services that a CCN or its subcontractors furnish to members and to DHH.

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

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

Federal Financial Participation (FFP) - Also known as federal match, the percentage of Federal matching dollars available to a state to provide Medicaid and CHIP services. The Federal Medical Assistance Percentage (FMAP) is calculated annually based on a formula designed to provide a higher Federal matching rate to states with lower per capital income.

Federally Qualified Health Center (FQHC) - An entity that receives a grant under Section 330 of the Public Health Service Act, as amended (Also see Section 1905(1)(2)(B) of the Social Security Act) to provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.

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

FFS Provider - An institution, facility, agency, person, corporation, partnership, or association approved by DHH which accepts payment in full for providing benefits, with the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.

Fiscal Intermediary (FI) - DHH's designee or agent responsible in the current delivery model for an array of support services including MMIS development and support, claims processing, pharmacy support services, provider support services, financial and accounting systems, prior authorization and utilization management, fraud and abuse systems, and decision support.

Fiscal Year (FY) – Refer to budget year - Federal Fiscal Year: October 1 through September 30 (FFY); State Fiscal Year (SFY): July 1 through June 30.

Fraud – As relates to the Medicaid Program Integrity, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law. Fraud may include deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received.

Full-Time Equivalent Position (FTE) – Refers to the equivalent of one (1) individual full-time employee who works forty (40) hours per week; or a full-time primary care provider shall be defined as one delivering outpatient preventive and primary (routine, urgent and acute) care for twenty (20) hours or more per week (exclusive of travel time).

GEO Coding – Refers to the process in which implicit geographic data is converted into explicit or map-form images.

GEO Mapping - The process of finding associated geographic coordinates (often expressed as latitude and longitude) from other geographic data, such as street addresses, or zip codes (postal codes). With geographic coordinates, the features can be mapped and entered into Geographic Information Systems, or the coordinates can be embedded into media.

Geographic Service Area (GSA) – The designated geographical service area in which a CCN is authorized by the contract to deliver enhanced primary care case management services to eligible Medicaid enrollees. The minimum geographic service area a CCN may provide services shall be as follows: GSA A consists of DHH Administrative Regions 1 and 9; GSA B consists of DHH Administrative Regions 2, 3 and 4; and GSA C consists of DHH Administrative Regions 5, 6, 7 and 8.

Go-Live Date – The date the CCN shall begin providing services to Medicaid members.

Good Cause – see "cause".

Grievance – An expression of member/provider dissatisfaction about any matter other than an action, as action is defined. Examples of grievances include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.

Health Care Professional - A physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law. Other health care practitioner includes any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician

Health Care Provider - a health care professional or entity who provides health care services or goods.

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

Health Information Technology for Economic and Clinical Health Act (HITECH Act) Title IV - The legislation establishes a transparent and open process for the development of standards that will allow for the nationwide electronic exchange of information between doctors, hospitals, patients, health plans, the government and others by the end of 2009. It establishes a voluntary certification process for health information technology products. The National Institute of Standards and Technology will provide for the testing of such products to determine if they meet the national standards that allow for the secure electronic exchange and use of health information.

HIPAA – (Health Information Portability and Accountability Act)

HIPAA Privacy Rule (45 CFR Parts 160 & 164) – Standards for the privacy of individually identifiable health information.

HIPAA Security Rule (45 CFR Parts 160 & 164) – A set of federal regulations promulgated pursuant to HIPAA which requires covered entities to maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of their Electronic Protected Health Information against any reasonably anticipated risks.

Historical Provider Relationship - The provider who has been the main source of Medicaid services for the member during the previous year (decided on by the most recent CommunityCARE 2.0 PCP, or if not previously CommunityCARE 2.0 by the provider {PCP or specialist}in the previous 12 months with whom the member had the most visits).

Home and Community Based Services Waiver (HCBS) - Under Section 1915 (c) of the Social Security Act, states may request waivers of state wideness, comparability of services, and community income and resource rules for the medically needy in order to develop Medicaid-financed community-based treatment alternatives. Non-state plan services that may be offered include case management, homemaker/home health aide services, personal care services, adult day health, habilitation, and respite care. Current HCBS waivers in Louisiana are New Opportunities Waiver (NOW), Children's Choice, Elderly and Disabled Adult Waiver, Adult Day Health Care, Supports Waiver, and Adult Residential Options.

ICD-9-CM codes – International Classification of Diseases, 9th Revision, Clinical Modification codes represent a uniform, international classification system of coding disease and injury diagnoses. This coding system arranges diseases and injuries into code categories according to established criteria. CCNs shall move to ICD-10-CM as it becomes effective.

IEP Services - These are therapies included in the student's Individualized Education Plan (IEP). Included are physical therapy, occupational therapy, speech/language therapy, audiology and some psychological therapy. The enrolled provider must be a public school system and they certify the state match via CPE. The school board does bill fee-for-service through the MMIS claims payment system which acts as an interim payment. At the end of the year there is a cost settlement process

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

Implementation Date – The date DHH notifies the CCN that network adequacy has been certified by DHH, CCN has successfully completed the Readiness Review and is approved to begin enrolling members.

Incentive Arrangement –Any payment mechanism under which a subcontractor may receive additional funds over and above the rate it was paid for meeting targets specified in the subcontract.

Incurred But Not Reported (IBNR) - Services rendered for which claim/encounter has not been received by the CCN.

Individual Practice - Independent physicians who work in their own private practices.

Individuals with Disabilities Education Act (IDEA) - A United States federal law that ensures services to children with disabilities throughout the United States. IDEA governs how states and public agencies provide early intervention, special education and related services to children with disabilities.

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

Insolvency - A financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets,.

Institutionalized – A patient in a nursing facility; an in-patient in a medical institution or institution for mental disease, whereby payment is based on a level of care provided in a nursing facility; or receives home and community-based waiver services.

Investigational Procedure/Service – see Experimental Procedure/Service.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) - An organization that operates accreditation programs to subscriber hospitals and other healthcare organizations.

KIDMED - Louisiana's name for the screening component for the Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) program provided for Medicaid eligible children under the age of 21. Required by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89).

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

LaCHIP (Louisiana Children's Health Insurance Program) - Refers to the Louisiana's Medicaid expansion CHIP (Title XXI) Program that provides health coverage to uninsured children under age 19, whose families have a net income up to 200 percent of the Federal Poverty Level (FPL); and whose income exceeds the Medicaid limit. Phase I includes children ages 6-18 with income from 100% up to and including 133% FPL; Phase II includes children with income from 134% up to and including 150% FPL; Phase III includes children with income from 151% FPL up to and including 200% FPL.

LaCHIP Affordable Plan (Phase V) – Louisiana's separate state CHIP (Title XXI) program that provides health coverage to uninsured children in families with income

from 201% up to and including 250% FPL. The program is administered by the Louisiana Office of Group Benefits.

LaCHIP Prenatal Program (Phase IV) – Louisiana's separate CHIP (Title XXI) program that provides prenatal coverage through the Medicaid delivery system from conception to birth for children whose uninsured mothers are ineligible for Medicaid and have net family income at or below 200% FPL..

LaMOMS - Medicaid program for pregnant women with income up to and including 133% FPL and optional Medicaid program for pregnant women with income from 134% up to and including 185% FPL. With a 15% income disregard, the income limit is in effect, 200% FPL. The program provides pregnancy-related services, delivery and post-partum care for 60 days after the pregnancy ends for women whose sole basis of eligibility is pregnancy.

Louisiana Department of Health and Hospitals (DHH) – The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Louisiana.

Louisiana Health Insurance Premium Payment Program (LaHIPP) – a Louisiana Medicaid program that pays for some or all of the health insurance premiums for an employee and their family if they have insurance available through their jobs and someone in the family has Medicaid.

Louisiana Medicaid State Plan – The binding written agreement between DHH and CMS which describes how the Medicaid program is administered and determines the services DHH will receive federal financial participation.

Major Subcontractor - Any entity with a Major Subcontract with the CCN. For the purposes of this Agreement, Material Subcontractors do not include providers in the MCO's Provider Network. Material Subcontractors may include, without limitation, Affiliates, subsidiaries, and affiliated and unaffiliated third parties.

Mandatory Population/Enrollee – The groups of eligible Medicaid eligibles who are required to enroll in a Medicaid CCN and whose participation is not voluntary.

Mandatory Population/Eligible – The categories of eligible Medicaid eligibles who are required to enroll in a Medicaid CCN and whose participation is not voluntary.

Marketing means any communication, from an CCN to a Medicaid eligible who is not enrolled in that CCN, that can reasonably be interpreted as intended to influence the recipient to enroll in that particular CCN's Medicaid product, or either to not enroll in, or to disenroll from, another CCN's Medicaid product.

Marketing Materials - Information produced in any medium, by or on behalf of a CCN that can reasonably be interpreted as intended to market to potential enrollees or members.

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

Material Change – Material changes are changes affecting the delivery of care or services provided under this RFP. Material changes include, but are not limited to, changes in: composition of the provider network, subcontractor network, CCN's complaint and grievance procedures; health care delivery systems, services, changes to expanded services; benefits; geographic service area; enrollment of a new population; procedures for obtaining access to or approval for health care services; any and all policies and procedures that required DHH approval prior to implementation; and the CCN's capacity to meet minimum enrollment levels. DHH shall make the final determination as to whether a change is material.

Material Subcontract - Any contract, subcontract, or agreement between the CCN and another entity that meets any of the following criteria:

- the other entity is an affiliate of the CCN;
- the subcontract is considered by DHH to be for a key type of service or function, including
- administrative services (including but not limited to third party administrator, network administration, and claims processing);
- delegated Networks (including but not limited to vision)
- management services (including management agreements with parent)
- reinsurance;
- disease management;
- call lines (including nurse and medical consultation); or
- any other subcontract that is, or is reasonably expected to be, more than $200,000 per year. Any subcontracts between the CCN and a single entity that are split into separate agreements by time period, GSA, etc., will be consolidated for the purpose of this definition.

For the purposes of this RFP, material subcontracts do not include contracts with any non-affiliates for any of the following, regardless of the value of the contract: utilities (e.g., water, electricity, telephone, Internet), mail/shipping, office space, or computer hardware.

Major Subcontractor - Means any entity with a major subcontract with the CCN. For the purposes of this Contract, major subcontractors do not include providers in the CCN's provider network. Major subcontractors may include, without limitation, affiliates, subsidiaries, and affiliated and unaffiliated third parties.

Mandatory Population/Enrollee – The groups of Medicaid eligibles who are required to enroll in a Medicaid CCN and whose participation is not voluntary.

Marketing - Means any communication, from an CCN to a Medicaid enrollee who is not enrolled in that CCN, that can reasonably be interpreted as intended to influence the recipient to enroll in that particular CCN's Medicaid product, or either to not enroll in, or to disenroll from, another CCN's Medicaid product.

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

Medicaid Eligible – Refers to an individual determined eligible, pursuant to federal and state law, to receive medical care, goods and services for which DHH may make payments under the Medicaid or CHIP Programs, who is enrolled in the Medicaid or CHIP Program, and on whose behalf payments may or may not have been made.

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

Medicaid Eligibility Office – DHH offices located within select parishes of the state and centralized State Office operations that are responsible for initial and ongoing Medicaid financial eligibility determinations.

Medicaid Eligible – Refers to an individual determined eligible, pursuant to federal and state law, to receive medical care, goods and services for which DHH may make payments under the Medicaid or CHIP Programs, who is enrolled in the Medicaid or CHIP Program, and on whose behalf payments may or may not have been made.

Medicaid FFS Provider - An institution, facility, agency, person, corporation, partnership, or association that has signed a PE 50 agreement, been approved by DHH, and accepts payment in full for providing benefits, the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.

Medicaid Management Information System (MMIS) – Mechanized claims processing and information retrieval system which all states Medicaid programs are required to have and which must be approved by the Secretary of DHHS. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid Providers and Eligibles.

Medicaid Recipient – An individual who has been determined eligible, pursuant to federal and state law, to receive medical care, goods or services for which DHH may make payments under the Medicaid or CHIP Program, who may or may not be currently enrolled in the Medicaid or CHIP Program, and on whose behalf payment is made.

Medical Director - The licensed physician designated by the CCN to exercise general supervision over the provision of core benefits and services by the CCN.

Medical Home – Systems of care led by a team of primary care providers who partner with the patient, the patient's family and the community to coordinate care in all settings, from specialists and hospitals to pharmacies, nursing homes and home health agencies. Primary care providers are inclusive of physician-led and nurse-practitioner-led primary care practices.

Medical Loss Ratio- The percentage of PMPM payments received from DHH used to pay medical claims from providers and spent for quality improvement.

Medical Record - A single complete record kept at the site of the member's treatment(s), which documents all of the treatment plans developed, including, but not limited to, outpatient and emergency medical health care services whether provided by the CCN, its subcontractor, or any out-of-network providers. The records may be electronic, paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 CFR § 456.111 and 42 CFR § 456.211.

Medical Vendor Administration (MVA) – Refers to the name for the budget unit specified in the Louisiana state budget that contains the administrative component of the Bureau of Health Services Financing (Louisiana's single state Medicaid agency).

Medically Necessary Services – As defined in LAC 50:I.1101 for medical necessity determination. Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: 1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and 2) not more costly than an alternative service or sequence of services at least as like to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary." The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing services at his discretion on a case-by-case basis.

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

Member – As it relates to the Louisiana Medicaid Program and this RFP, refers to a Medicaid eligible who enrolls in a CCN under the provisions of this RFP and also refers to "enrollee" as defined in 42 CFR § 438.10(a).

Member Materials - Means all written materials produced or authorized by the CCN and distributed to members or potential members containing information concerning

the CCN Program(s). Member materials include, but are not limited to, member ID cards, member handbooks, provider directories, and marketing materials.

Member Month – A month of coverage for a Medicaid eligible who is enrolled in the CCN.

Medicaid Management Information System (MMIS) – Mechanized claims processing and information retrieval system which all states Medicaid programs are required to have and which must be approved by the Secretary of DHHS. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid Providers and Eligibles.

Methodology - Means the planned process, steps, activities or actions taken by a CCN to achieve a goal or objective, or to progress toward a positive outcome.

Monetary Penalties – Monetary sanctions that may be assessed whenever a CCN, its providers, and/or its subcontractors fail to achieve certain performance standards and other items defined in the terms and conditions of the Contract.

Monitoring - The process of observing, evaluating, analyzing and conducting follow-up activities.

Must – Denotes a mandatory requirement.

National Response Framework - Part of the Federal Emergency Management Agency (FEMA), The National Response Framework presents the guiding principles that enable all response partners to prepare for and provide a unified national response to disasters and emergencies. The framework establishes a comprehensive, national, all-hazards approach to domestic incident response.

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

Network – As utilized in the RFP, "network" may be defined as a group of participating providers linked through subcontractual arrangements to a CCN to supply a range of primary and acute health care services. Also referred to as Provider Network.

Network Adequacy - Refers to the network of health care providers for a CCN that is sufficient in numbers and types of providers and facilities to ensure that all services are accessible to members without unreasonable delay. Adequacy is determined by a

number of factors, including but not limited to, provider/patient ratios; geographic accessibility and travel distance; waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments and hours of provider operations.

Newborn - A live infant born to a CCN member.

Non-Contracting Provider - A person or entity that provides hospital or medical care but does not have a contract or subcontract with the CCN.

Non-Covered Services - Services not covered under the Title XIX Louisiana State Medicaid Plan.

Non-Emergency Medical Transportation (NEMT) - A ride, or reimbursement for a ride, provided so that a member with no other transportation resources can receive services from a medical provider. NEMT does not include transportation provided on an emergency basis, such as trips to the emergency room in life threatening situations.

Non-Emergency Medical Transportation (NEMT) - transportation resources can receive services from a medical provider. NEMT does not include transportation provided on an emergency basis, such as trips to the emergency room in life threatening situations.

Non-Participating Physician - A physician licensed to practice that has not contracted with or is not employed by the CCN to provide health care services.

Non-Urgent Sick Care – Medical care given for an acute onset of symptoms that is not emergent or urgent in nature. Examples of non-urgent sick visit include cold symptoms, sore throat, and nasal congestion; requires face-to-face medical attention within 72 hours of member notification of a non-urgent condition, as clinically indicated.

Nurse Practitioner (NP) - An advanced practice registered nurse educated in a specified area of care and certified according to the requirements of a nationally recognized accrediting agency such as the American Nurses Association's American Nurses Credentialing Center, National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties, or the National Certification Board of Pediatric Nurse Practitioners and Nurses, or as approved by the state board of nursing and who is authorized to provide primary, acute, or chronic care, as an advanced nurse practitioner acting within his/her scope of practice to individuals, families, and other groups in a variety of settings including, but not limited to, homes, institutions, offices, industry, schools, and other community agencies.

Open Enrollment - The period of time when a CCN member may change CCNs without cause *(once per year after initial enrollment)*.

Open Panel - PCPs who are accepting new patients for the Louisiana Medicaid CCN program.

Operational Start Date - Means the first day on which a CCN is responsible for providing enhanced primary care services to CCN members and all related Contract functions in a Geographic Service Area. The Operational start date may vary per CCN and GSA. The Operational Start Date(s) applicable to this Contract are set forth in the Contract between DHH and the CCN.

Out-of-Network - An appropriately licensed individual, facility, agency, institution, organization or other entity that has not entered into a contract with the CCN for the delivery of covered services to the CCN's members.

Ownership Interest - The possession of stock, equity in the capital, or any interest in the profits of the CCN, for further definition see 42 CFR 455.101 (2005).

Per Capita Prepaid Benchmark (PCPB, the benchmark) – The projected medical costs of the CCN member for the evaluation period. The benchmark will be risk-adjusted based upon the health risk associated with the CCN membership. The risk-adjusted benchmark is compared to the sum of actual cost and paid enhanced primary care case management fees to determine if shavings have been achieved.

Per Member Per Month (PMPM) – The amount of money paid or received on a monthly basis for each individual enrolled.

Performance Concern - The informal documentation of an issue. The CCN is required to respond to the performance concern by defining a process to detect, analyze and eliminate non-compliance and potential causes of non-compliance. This is a "warning" and failure to comply with the Corrective Action Plan and/or continued non-compliance may result in formal action against the CCN. If there is a Performance Concern, the following information must be provided to DHH by the CCN: 1) Direct Cause - The cause that directly resulted in the event (the first cause in the chain) and 2) Corrective Action:- actions taken and/or that will be taken to correct the root cause, generally a reactive process used to address problems after they have occurred.

Performance Improvement Projects (PIP) – Projects to improve specific quality performance measures through ongoing measurements and interventions that result in significant improvement, sustained over time, with favorable effect on health outcomes and member satisfaction.

Performance Measures – Specific operationally defined performance indicators utilizing data to track performance and quality of care and to identify opportunities for improvement related important dimensions of care and service.

Personal Health Record (PHR) – A health record that is initiated and maintained by an individual.

Physician Assistant - A health care professional who is a graduate of a program accredited by the Committee on Allied Health Education and Accreditation or its successors and who has successfully passed the national certificate examination administered by the National Commission on the Certification of Physicians' Assistants or its predecessors and who is approved and licensed by the Louisiana State Board of Medical Examiners to perform medical services under the supervision of a physician or group of physicians who are licensed and registered with the board to supervise such assistant. A physician assistant may perform certain duties such as history taking, diagnosis, drawing blood samples, urinalysis, and injections under the supervision of a physician.

Physician Extender –Nurse practitioners, certified nurse mid-wives, and physician assistants linked to a physician group who provide primary care services.

Physician Practice Connections®Patient-Center Medical Home (PPC-PCMH™) – NCQA recognition for physician practices that meet specific criteria for medical homes.

Plan of Care – Strategies designed to ***Guide*** health care professionals involved with patient care. Such plans are patient specific and are meant to address the total status of the patient. Care plans are intended to ensure optimal outcomes for patients during the course of their care.

PMPM Rate - The per-member, per-month rate paid to the CCN by DHH for the provision of enhanced primary care case management services to CCN members.

Policies - The general principles by which DHH is guided in its management of the Title XIX program, and as further defined by DHH promulgations and by state and federal rules and regulations.

Post-Stabilization Care Services - Covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain, improve or resolve the member's condition pursuant to 42 CFR § 438.114(a) and § 1852(d)(2) of the Social Security A).

Potential enrollee - means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a CCN, but is not yet an enrollee of a specific CCN.

Poverty Level – Poverty guidelines issued annually in late January or early February by the Department of Health & Human Services for the purpose of determining financial eligibility for certain programs including Medicaid and CHIP and which are based on household size.

Pre-Processing – As it relates to the CCN Program, is the processing of all claims by a CCN for services provided to CCN members by Medicaid providers to verify service authorizations and ensure only clean claims are submitted to the FI for payment.

Preventive Care – Refers to the treatment to avert disease/illness and/or its consequences. The term is used to designate prevention and early detection programs rather than restorative or treatment programs. There are three levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred; requires a face-to-face visit within 4 weeks of member request.

Primary Care Case Management – A system under which a PCCM contracts with the state to furnish primary care case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid recipients.

Primary Care Case Manager (PCCM) – A physician, physician group practice, or entity that employs or arranges with physicians to furnish primary care case management services.

Primary Care Provider (PCP) - An individual physician or other licensed nurse practitioner responsible for the management of a member's health care who is licensed and certified in one of the following general specialties; family practitioner, general practitioner, general pediatrician, general internal medicine, general internal medicine and pediatrics, or obstetrician/ gynecologist. The primary care provider is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care), or admit the patient to a hospital.

Primary Care Services - Health care services and laboratory services customarily furnished by or through a primary care provider for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, health maintenance, and health promotion either through, direct service to the member when possible, or through appropriate referral to specialists and/or ancillary providers.

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

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

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

Provider – Either (1) for the fee-for-service program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the CCN Program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers services.

Provider Complaint - Any issue or dispute that arises between a provider and a CCN that is not the result of a provider acting on behalf of an enrollee in the grievance and appeal process and is related to unique administrative functions of the CCN. Provider complaints may include, but are not limited to, PCP auto-assignment process, rude CCN staff, and network contracting. The CCN Provider complaint process does not include MMIS provider payment issues.

Provider Directory - A listing of health care service providers under contract with the CCN that is prepared by the CCN as a reference tool to assist members in locating providers that are available to provide services.

Provider Subcontract - An agreement between a CCN and a provider of services to furnish core benefits and services to members, or with a marketing organization, or with any other organization or person who agrees to perform any administrative function or service for the CCN specifically related to fulfilling the CCN's obligations under the terms of this RFP.

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

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

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

Quality Assessment and Improvement (QAPI) Plan – A written plan, required of all CCN-S entities, detailing quality management and committee structure, performance measures, monitoring and evaluation process and improvement activities measures that rely upon quality monitoring implemented to improve health care outcomes for enrollees.

Quality Management (QM) – The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical and behavioral health knowledge.

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

Recipient - An individual entitled to benefits under Title XIX or Title XXI of the Social Security Act, and under the Louisiana Medicaid State Plan who is or was enrolled in Medicaid and on whose behalf a payment has been made for medical services rendered.

Redacted Proposal – The removal of confidential and/or proprietary information from one copy of the proposal for public records purposes.

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

Referral Services - Health care services provided to CCN members to both in-and out-of-network when ordered and approved by the CCN, including, but not limited to in-network specialty care and out-of-network services which are covered under the Louisiana Medicaid State Plan.

Related Party - A party that has, or may have, the ability to control or significantly influence a contractor/subcontractor, or a party that is, or may be, controlled or significantly influenced by a contractor/subcontractor. "Related parties" include, but are not limited to, agents, management employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.

Relationship – Relationship is described as follows for the purposes of any business affiliations discussed in §15 and §18. A director, officer, or partner of the CCN; A person with beneficial ownership of five percent or more of the CCN's equity; or a person with an employment, consulting or other arrangement (e.g., providers) with the CCN.

Remittance Advice – An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only. Transactions may include but are not limited to, members enrolled in the CCN, payments for maternity, and adjustments

Representative - Any person who has been delegated the authority to obligate or act on behalf of another. Also known as the authorized representative.

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

RFP (Request for Proposal) – As relates to CCN, the process by which DHH invites proposals from interested parties for the procurement of specified services.

Risk - The chance or possibility of loss. As it relates to the CCN-S Program, the CCN may be at risk for up to fifty (50) percent of the enhanced primary care case management fee paid by DHH.

Risk Adjustment - A method that accounts for variation in health risks among participating CCNs when determining per capita prepaid benchmark (PCPB).

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

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

Rural Area – Refers to any parish within a Geographic Service Area that meets the Office of Management and Budget definition of rural. See Appendix Q of this RFP for map of Louisiana Rural Parishes)

Rural Health Clinic (RHC) – A clinic located in an area that has a healthcare provider shortage and is certified to receive special Medicare and Medicaid reimbursement. RHCs provide primary health care and related diagnostic services and may provide

optometric, podiatry, chiropractic and behavioral health services. RHCs must be reimbursed by the CCN using prospective payment system (PPS) methodology.

Rural Hospital - Shall be defined as small rural hospital as defined by R.S. 40:1300.143.

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

Scope of Services – See "enhanced primary care case management services."

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

Secondary Care - Health care services provided by medical specialists who generally do not have first contact with patients, but instead are referred to them by primary care providers.

Section 1931- Category of Medicaid eligibility for low-income parents who do not receive cash assistance but whose income is below Louisiana's 1996 Aid to Families with Dependent Children income threshold. Louisiana's name for this program is Low Income Families with Children (LIFC).

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

Security Rule (45 CFR Parts 160 & 164) – Part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which stipulates that covered entities must maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of their Electronic Protected Health Information against any reasonably anticipated risks.

Service Area – **T**he designated geographical service area(s) within which the CCN is authorized to furnish core benefits and services to enrollees. A service area shall not be less than one-GSA.

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

Shall - Denotes a mandatory requirement.

Should- Denotes a preference but not a mandatory requirement.

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

Significant Traditional Provider (STP) - Those Medicaid enrolled providers that provided the top eighty percent (80%) of Medicaid services by provider type (e. g. physician, hospital, lab and x-ray) for the CCN-eligible population in the base year of 2010.

Social Security Act - The current version of the Social Security Act of 1935 (42 U.S.C.A. § 301 et seq.) as amended which encompasses the Medicaid Program (Title XIX) and CHIP Program (Title XXI).

Solvency- The minimum standard of financial health for a CCN where assets exceed liabilities and timely payment requirements can be met.

Span of Control – Information systems and telecommunications capabilities that the CCN itself operates or for which it is otherwise legally responsible according to the contractual terms and conditions with DHH. The span of control also includes systems and telecommunications capabilities outsourced by the CCN.

Special Needs Population- An individual of any age with a mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care requirements.

Specialist/Specialty Services - A specialist/subspecialist is a health care professional who is not a primary care physician.

Start-Up Date – The date CCN providers begin providing medical care to their Medicaid members. Also referred to as "go-live date".

State - The state of Louisiana.

State Plan – Refers to the Louisiana Medicaid State Plan.

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

Subcontractor - A person, agency or organization with which a CCN has subcontracted or delegated some of its management functions or other contractual responsibilities to provide covered services to its members.

Subsidiary – Means an affiliate controlled by such person or entity directly or indirectly through one (1) or more intermediaries.

Subspecialist Services - See Specialty Services

Supplemental Security Income (SSI) – A federal program which provides a cash benefit to people who are aged, blind or disabled and who have little or no income or assets. Louisiana is a "Section 1634" state and anyone determined eligibility for SSI is automatically eligible for Medicaid.

SURS Reporting - Surveillance and Utilization Review Subsystems reporting as required in the subsection under Fraud, Abuse and Waste Prevention.

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

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

- *Record Search Time*-the time elapsed after the search command is entered until the list of matching records begins to appear on the monitor.
- *Record Retrieval Time*-the time elapsed after the retrieve command is entered until the record data begin to appear on the monitor.
- *Print Initiation Time*- the elapsed time from the command to print a screen or report until it appears in the appropriate queue.
- *On-line Claims Adjudication Response Time*- the elapsed time from the receipt of the transaction by the CCN from the provider and/or switch vendor until the CCN hands-off a response to the provider and/or switch vendor.

Targeted Case Management - Case management for a targeted population of persons paid by state plan. The State Plan defines special needs as: a documented, established medical condition, as determined by a licensed physician, that has a high probability of resulting in a developmental delay or that gives rise to a need for multiple medical, social, educational and other services. In the case of a hearing impairment, the determination of special needs must be made by a licensed audiologist or physician.

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

Third Party Liability (TPL) – Any monetary amount due for all or part of the cost of medical health care from a responsible third party.

Timely – Existing or taking place within the designated period; within the time required by statue or rules and regulations, contract terms, or policy requirements.

Title IV-E – Section of the Social Security Act of 1935 as amended that encompasses medical assistance for foster children and adoption assistance.

Title V – Section of the Social Security Act of 1935 as amended that encompasses maternal child health services.

Title X - Section of the Social Security Act of 1935 as amended that encompasses and governs family planning services.

Title XIX – Section of the Social Security Act of 1935, as amended, that encompasses and governs the Medicaid program.

Title XXI - Section of the Social Security Act of 1935, as amended, that encompasses and governs the Children's Health Insurance Program (CHIP).

Transition Phase - All activities the CCN is required to perform between the Contract effective date and the implementation date for a CCN Program and GSA.

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

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

Turnover Plan - The written plan developed by the CCN, approved by DHH, to be employed during the turnover phase.

Urban Area – Refers to a geographic area that meets the definition of urban area at 42 CFR §412.62(f)(1)(ii) which is a Metropolitan Statistical Area(MSA) as defined by the Executive Office of Management and Budget. A list of Louisiana parishes in Metropolitan Statistical Areas can be found at http://www.doa.louisiana.gov/census/metroareas.htm

Urgent Care - Medical care provided for a condition that without timely treatment, could be expected to deteriorate into an emergency, or cause prolonged, temporary

impairment in one or more bodily function, or cause the development of a chronic illness or need for a more complex treatment. (Examples of conditions that require urgent care include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, suspected fracture; urgent care requires timely face-to-face medical attention within 24 hours of member notification of the existence of an urgent condition.

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

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

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

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

Voluntary Population – Refers to categories of individuals eligible for, and enrolled n Louisiana Medicaid who are not mandated to enroll in a CCN. By default they will be included in the CCN program, if they do not opt out during the 30 day choice period.

Waiting Time(s) – Time spent both in the lobby and in the examination room prior to being seen by a provider.

Waiver - Medicaid Section 1915(c) Home and Community Based Services (HCBS) programs which in Louisiana are New Opportunities Waiver (NOW), Children's Choice, Adult Day Health Care (ADHC), Elderly Disabled and Adult (EDA), Supports Waiver, Residential Options Waiver (ROW), and any other 1915(c) waiver that may be implemented. Participants in waivers are excluded from enrolling in a CCN.

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

Will - Denotes a mandatory requirement.

Willful – Refers to conscious or intentional but not necessarily malicious act.

ACRONYMS

ADA – Americans with Disabilities Act

AFDC – Aid to Families with Dependent Children

BHS – Behavioral Health Services

BHSF – Bureau of Health Services Financing

CAHPS – The Consumer Assessment of Health Providers and Systems

CAP – Corrective Action Plan

CAH – Critical Access Hospital

CCMP – Chronic Care Management Program

CCN – Coordinated Care Network

CCN-P – Coordinated Care Network – Prepaid

CCN-S – Coordinated Care Network – Shared Savings

CDC – Centers for Disease Control and Prevention

CFR – Code of Federal Regulations

CHIP – Children's Health Insurance Program

CMS – Centers for Medicare and Medicaid Services

CPT – Current Procedural Terminology

DAL – Division of Administrative Law

DHH – Department of Health and Hospitals

DHHS – Department of Health and Humans Services (also HHS)

DM – Disease Management

DME – Durable Medical Equipment

DMEPOS – Durable Medical Equipment, Prosthetics Orthotics and certain Supplies
DOA – Division of Administration

EB – Enrollment Broker

EHR – Electronic Health Records

EPSDT - Early and Periodic Screening, Diagnosis and Treatment

EQR – External Quality Review

EQRO - External Quality Review Organization

FFP – Federal Financial Participation

FFS –- Fee for Service

FI – Fiscal Intermediary

FQHC – Federally Qualified Health Center

FTE – Full-Time Equivalent

FY – Fiscal Year

GSA – Geographic Service Area

HCBS – Home and Community Based Services Waiver

HCFA – Health Care Financing Administration

HEDIS – Healthcare Effectiveness Data and Information Set

HHS –Department of Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act

HITECH – Health Information Technology for Economic and Clinical Health Act

IBNR – Incurred But Not Reported

IDEA – Individuals with Disabilities Education Act

IEP – Individualized Education Plan

INS – U.S. Immigration and Naturalization Services

IS – Information Systems

JCAHO – Joint Commission on Accreditation of Healthcare Organizations

LaCHIP – Louisiana Children's Health Insurance Program

LaHIPP – Louisiana Health Insurance Premium Payment Program

LIFC – Low Income Families and Children

MMIS – Medicaid Management Information System

MVA – Medical Vendor Administration

NAIC – National Association of Insurance Commissioners

NCQA –National Committee for Quality Assurance

NEMT – Non-Emergency Medical Transportation

NP – Nurse Practitioner

PA –Physician's Assistant

PCCM – Primary Care Case Manager

PCP –Primary Care Provider

PCS – Personal Care Services

PHI – Personal Health Information

PHR – Personal Health Record

PIP – Performance Improvement Projects

PMPM – Per Member, Per Month

PPC – Provider Preventable Condition

PPC – PCMH ™ - Physician Practice Connections ® Patient-Center Medical Home

PPS –Prospective Payment System

QAPI –Quality Assessment and Performance Improvement Plan

QM – Quality Management

RFP – Request for Proposals

RHC – Rural Health Clinic

RN – Registered Nurse

SBHC – School Based Health Center

SFTP – Secure File Transfer Protocol

SSA – Social Security Act

SSI – Supplemental Security Income

STP – Significant Traditional Provider

TANF –Temporary Assistance for Needy Families

TPL – Third Party Liability

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

UM – Utilization Management

UR – Utilization Review

WIC – Women, Infants and Children Program

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APPENDICES

APPENDIX A

PROPOSAL CERTIFICATION STATEMENT

CERTIFICATION STATEMENT

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

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

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

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

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

1. The information contained in its response to this RFP is accurate;
2. Proposer accepts the procedures, evaluation criteria, contract terms and conditions, and all other administrative requirements set forth in this RFP.
3. Proposer accepts the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP.
4. Proposer's quote is valid for at least 120 days from the date of proposal's signature below;
5. Proposer understands that if selected as the successful Proposer, he/she will have seven (7) business days from the date of delivery of initial contract in which to complete contract negotiations, if any, and execute the final contract document. The Department has the option to waive this deadline if actions or inactions by the Department cause the delay.
6. Proposer certifies, by signing and submitting a proposal for $25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in OMB Circular A-133. (A list of parties who have been suspended or debarred can be viewed via the internet at www.epls.gov

Authorized Signature: _____

Typed or Printed Name: _____

Title: _____

Company Name: _____

Appendix B

DHH Standard Contract Form (CF-1)

DHH - CF - 1
Revised: 2010-08

CONTRACT BETWEEN STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

CFMS:

DHH:

Medical Vendor Administration

Agency #

AND

FOR

☐ Personal Services ☒ Professional Services ☐ Consulting Services ☐ Social Services

1) **Contractor (Legal Name if Corporation)**	5) **Federal Employer Tax ID# or Social Security # (Must be 11 Digits)**
2) **Street Address**	6) **Parish(es) Served**
City / **State** LA / **Zip Code**	7) **License or Certification #**
3) **Telephone Number**	8) Contractor Status Subrecipient: ☐ Yes ☐ No Corporation: ☐ Yes ☐ No For Profit: ☐ Yes ☐ No Publicly Traded: ☐ Yes ☐ No
4) **Mailing Address (if different)**	
City / **State** / **Zip Code**	8a) **CFDA#**(Federal Grant #)

9) **Brief Description Of Services To Be Provided:**
Contractor shall provide a broad range of services necessary for the delivery of healthcare services to Medicaid enrollees participating in the Medicaid Coordinated Care Network (CCN) Program, utilizing the most cost effective manner. Such services include developing and maintaining an adequate provider network, access standards, utilization management, quality management, prior authorization, provider monitoring, member and provider services, primary care management, fraud and abuse monitoring and compliance, case management, chronic care management and account management. This contract includes such duties as 24/7 access to a health care professional, service authorization, provider payments, claims management, marketing and member education. See Statement of Work.

10) **Effective Date** 01-01-2012

11) **Termination Date** 12-31-2014

12) This contract may be terminated by DHH upon giving sixty (60) days advance written notice to the other party with or without cause but in no case shall continue beyond the specified termination date.

13) **Maximum Contract Amount**

14) **Terms of Payment**
If progress and/or completion of services are provided to the satisfaction of the initiating Office/Facility, payments are to be made as follows:
DHH shall make monthly capitated payments for each member enrolled into the CCN. The CCN shall agree to accept, as payment in full, the actuarially sound rate and maternity kick payment established by DHH pursuant to the contract, and shall not seek additional payment from a member, or DHH, for any unpaid cost. DHH reserves the right to defer remittance of the PMPM payment for June until the first Medicaid Management Information System (MMIS) payment cycle in July to comply with state fiscal policies and procedures.

Contractor obligated to submit final invoices to Agency within fifteen (15) days after termination of contract.

PAYMENT WILL BE MADE ONLY UPON APPROVAL OF:	**First Name**	**Last Name**
	Title	**Phone Number**

15) **Special or Additional Provisions which are incorporated herein, if any (IF NECESSARY, ATTACH SEPARATE SHEET AND REFERENCE):**

During the performance of this contract, the Contractor hereby agrees to the following terms and conditions:

1. Contractor hereby agrees to adhere as applicable to the mandates dictated by Titles VI and VII of the Civil Rights Act of 1964, as amended; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; Americans with Disabilities Act of 1990 as amended; the Rehabilitation Act of 1973 as amended; Sec. 202 of Executive Order 11246 as amended, and all applicable requirements imposed by or pursuant to the regulations of the U. S. Department of Health and Human Services. Contractor agrees not to discriminate in the rendering of services to and/or employment of individuals because of race, color, religion, sex, age, national origin, handicap, political beliefs, disabled veteran, veteran status, or any other non-merit factor.

2. Contractor shall abide by the laws and regulations concerning confidentially which safeguard information and the patient/client confidentiality. Information obtained shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (The Contractor shall establish, subject to review and approval of the Department, confidentiality rules and facility access procedures.)

3. The State Legislative Auditor, Office of the Governor, Division of Administration, and Department Auditors or those designated by the Department shall have the option of auditing all accounts pertaining to this contract during the contract and for a three year period following final payment. Contractor grants to the State of Louisiana, through the Office of the Legislative Auditor, Department of Health and Hospitals, and Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours.

   Contractor shall comply with federal and state laws and/or DHH Policy requiring an audit of the Contractor's operation as a whole or of specific program activities. Audit reports shall be sent within thirty (30) days after the completion of the audit, but no later than six (6) months after the end of the audit period. If an audit is performed within the contract period, for any period, four (4) copies of the audit report shall be sent to the Department of Health and Hospitals, Attention: **Division of Fiscal Management, P.O. Box 91117, Baton Rouge, LA 70821-3797** and one (1) copy of the audit shall be sent to the **originating DHH Office**.

4. Contractor agrees to retain all books, records and other documents relevant to the contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 74:53 (b) whichever is longer. Contractor shall make available to the Department such records within thirty (30) days of the Department's written request and shall deliver such records to the Department's central office in Baton Rouge, Louisiana, all without expense to the Department. Contractor shall allow the Department to inspect, audit or copy records at the contractor's site, without expense to the Department.

5. Contractor shall not assign any interest in this contract and shall not transfer any interest in the same (whether by assignment or novation), without written consent of the Department thereto, provided, however, that claims for money due or to become due to Contractor from the Department under this contract may be assigned to a bank, trust company or other financial institution without advanced approval. Notice of any such assignment or transfer shall be promptly furnished to the Department and the Division of Administration, Office of Contractual Review.

6. Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this contract shall be Contractor's. The contractor assumes responsibility for its personnel providing services hereunder and shall make all deductions for withholding taxes, and contributions for unemployment compensation funds.

7. Contractor shall obtain and maintain during the contract term all necessary insurance including automobile insurance, workers' compensation insurance, and general liability insurance. The required insurances shall protect the Contractor, the Department of Health and Hospitals, and the State of Louisiana from all claims related to Contractor's performance of this contract. Certificates of Insurance shall be filed with the Department for approval. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days advance written notice to the Department. Commercial General Liability Insurance shall provide protection during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as claims for property damages, with combined single limits prescribed by the Department.

8. ~~In cases where travel and related expenses are required to be identified separate from the fee for services, such costs shall be in accordance with State Travel Regulations. The contract contains a maximum compensation which shall be inclusive of all charges including fees and travel expenses.~~

9. No funds provided herein shall be used to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition or any election ballot or a proposition or matter having the effect of law being considered by the legislature or any local governing authority. Contracts with individuals shall be exempt from this provision.

10. ~~Should contractor become an employee of the classified or unclassified service of the State of Louisiana during the effective period of the contract, Contractor must notify his/her appointing authority of any existing contract with State of Louisiana and notify the contracting office of any additional state employment. This is applicable only to contracts with individuals.~~

11. All non-third party software and source code, records, reports, documents and other material delivered or transmitted to Contractor by State shall remain the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract. All non-third party software and source code, records, reports, documents, or other material related to this contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract.

12. Contractor shall not enter into any subcontract for work or services contemplated under this contract without obtaining prior written approval of the Department. Any subcontracts approved by the Department shall be subject to conditions and provisions as the Department may deem necessary; provided, however, that notwithstanding the foregoing, unless otherwise provided in this contract, such prior written approval shall not be required for the purchase by the contractor of supplies and services which are incidental but necessary for the performance of the work required under this contract. No subcontract shall relieve the Contractor of the responsibility for the performance of contractual obligations described herein.

13. No person and no entity providing services pursuant to this contract on behalf of contractor or any subcontractor is prohibited from providing such services by the provisions of R.S. 1113 as amended in the 2008 Regular Session of the Louisiana Legislature.

14. No claim for services furnished or requested for reimbursement by Contractor, not provided for in this contract, shall be allowed by the Department. In the event the Department determines that certain costs which have been reimbursed to Contractor pursuant to this or previous contracts are not allowable, the Department shall have the right to set off and withhold said amounts from any amount due the Contractor under this contract for costs that are allowable.

15. This contract is subject to and conditioned upon the availability and appropriation of Federal and/or State funds; and no liability or obligation for payment will develop between the parties until the contract has been approved by required authorities of the Department; and, if contract exceeds $20,000, the Director of the Office of Contractual Review, Division of Administration in accordance with La. R.S. 39:1502..

16. The continuation of this contract is contingent upon the appropriation of funds from the legislature to fulfill the requirements of the contract. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

17. Any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when reduced to writing, as an amendment duly signed, and approved by required authorities of the Department; and, if contract exceeds $20,000, approved by the Director of the Office of Contractual Review, Division of Administration. Budget revisions approved by both parties in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.

18. Any contract disputes will be interpreted under applicable Louisiana laws and regulations in Louisiana administrative tribunals or district courts as appropriate.

19. Contractor will warrant all materials, products and/or services produced hereunder will not infringe upon or violate any patent, copyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against DHH, the Department shall promptly notify Contractor in writing and Contractor shall defend such claim in DHH's name, but at Contractor's expense and shall indemnify and hold harmless DHH against any loss, expense or liability arising out of such claim, whether or not such claim is successful. This provision is not applicable to contracts with physicians, psychiatrists, psychologists or other allied health providers solely for medical services.

20. ~~Any equipment purchased under this contract remains the property of the Contractor for the period of this contract and future continuing contracts for the provision of the same services. Contractor must submit vendor invoice with reimbursement request. For the purpose of this contract, equipment is defined as any tangible, durable property having a useful life of at least (1) year and acquisition cost of $1000.00 or more. The contractor has the responsibility to submit to the Contract Monitor an inventory list of DHH equipment items when acquired under the contract and any additions to the listing as they occur. Contractor will submit an updated, complete inventory list on a quarterly basis to the Contract Monitor. Contractor agrees that upon termination of contracted services, the equipment purchased under this contract reverts to the Department. Contractor agrees to deliver any such equipment to the Department within 30 days of termination of services.~~

21. Contractor agrees to protect, indemnify and hold harmless the State of Louisiana, DHH, from all claims for damages, costs, expenses and attorney fees arising in contract or tort from this contract or from any acts or omissions of Contractor's agents, employees, officers or clients, including premises liability and including any claim based on any theory of strict liability. This provision does not apply to actions or omissions for which LA R.S. 40:1299.39 provides malpractice coverage to the contractor, nor claims related to treatment and performance of evaluations of persons when such persons cause harm to third parties (R.S. 13:5108.1(E)). Further it does not apply to premises liability when the services are being performed on premises owned and operated by DHH.

22. Any provision of this contract is severable if that provision is in violation of the laws of the State of Louisiana or the United States, or becomes inoperative due to changes in State and Federal law, or applicable State or Federal regulations.

23. Contractor agrees that the current contract supersedes all previous contracts, negotiations, and all other communications between the parties with respect to the subject matter of the current contract.

THIS CONTRACT CONTAINS OR HAS ATTACHED HERETO ALL THE TERMS AND CONDITIONS AGREED UPON BY THE CONTRACTING PARTIES. IN WITNESS THEREOF, THIS CONTRACT IS SIGNED ON THE DATE INDICATED BELOW.

	STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
SIGNATURE **DATE**	**SIGNATURE** **DATE**
NAME	**NAME** Secretary, Department of Health and Hospital or Designee
TITLE	**TITLE**
	Medical Vendor Administration
SIGNATURE **DATE**	**SIGNATURE** **DATE**
NAME	**NAME**
TITLE	**TITLE**

Appendix C

HIPAA Business Associate Agreement

HIPAA BUSINESS ASSOCIATE AGREEMENT

A. Purpose

The Louisiana Department of Health and Hospitals (Covered Entity) and CCN (Business Associate) agree to the terms of this Agreement for the purpose of protecting the privacy of individually identifiable health information under the Health Insurance Portability and Accountability Act of 1996, Public Law No. 104-191 ("HIPAA"), and regulations promulgated there under by the U.S. Department of Health and Human Services (the "HIPAA Regulations"); and Subtitle D of the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), also known as Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law No. 111-005 ("ARRA") in performing the functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract between the parties.

B. Definitions (Other terms used but not defined shall have the same meaning as those terms in the HIPAA Privacy Rule.)

1. Business Associate means the same as "business associate" in 45 CFR § 160.103.

2. Covered Entity means DHH.

3. Designated Record Set means the same as "designated record set" in 45 CFR § 164.501.

4. Individual means the same as "individual" in 45 CFR § 160.103 and includes a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

5. Privacy Rule means the HIPAA Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 160 and Part 164, Subparts A and E).

6. Protected Health Information (PHI) means the same as the term protected health information in 45 CFR § 160.103, limited to information received by Agency from Covered Entity.

7. Required By Law means the same as "required by law" in 45 CFR § 164.103, and other law applicable to the PHI disclosed pursuant to the Contract.

8. Secretary means the Secretary of the Department of Health and Hospitals or designee.

9. Security Standards shall mean the Security Standards at 45 C.F.R. Part 160 and

Part 164, as may be amended.

10. Electronic PHI shall have the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103.

11. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system or its current meaning under 45 C.F.R. § 164.304.

C. Business Associate Provisions

Business Associate agrees to:

1. Not use or disclose PHI other than as permitted or required by the Contract or as required by law.

2. Use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for in the Contract.

3. Mitigate to the extent practicable, any harmful effect known to Business Associate if it uses/discloses PHI in violation of the Contract.

4. Immediately report to Covered Entity any breaches in privacy or security that compromise PHI. Security and/or privacy breaches should be reported to:

   Louisiana Department of Health and Hospitals
   Bureau of Legal Services
   Post Office Box 3836
   Baton Rouge, Louisiana 70821
   Phone: (225) 342-1112
   Fax: (225) 342-2232

   The Report should include a detailed description of the breach and any measures that have been taken by the Business Associate to mitigate the breach.

   DHH may impose liquidated damages of $300 per day from the date that the Business Associate knew or should have known of any breach in privacy or security that compromises PHI to the date that DHH becomes aware of the breach.

   DHH may impose liquidated damages of up to $25,000 for any breach in privacy or security that compromises PHI.

5. Ensure that any agent/contractor to whom it provides PHI agrees to the same restrictions/conditions that apply to the Business Associate in this Agreement.

6. If the Business Associate has PHI in a designated record set: (1) provide access at Covered Entity's request to PHI to Covered Entity or, as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR § 164.524; (2) make any amendment(s) to PHI in a designated record set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526.

7. Make its internal practices, books, records, and policies/procedures relating to the use/disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity, to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

8. Document Business Associate disclosures of PHI, other than disclosures back to Covered Entity, and related information as would be required for Covered Entity to respond to a request for an accounting of PHI disclosures in accordance with 45 CFR § 164.528.

9. Provide to Covered Entity or an individual, as designated by Covered Entity, information collected in accordance with Section C.8 of this Agreement, to permit Covered Entity to respond to a request for an accounting of PHI disclosures in accordance with 45 CFR § 164.528.

10. Encrypt all PHI stored on portable devices. Portable devices include all transportable devices that perform computing or data storage, manipulation or transmission including, but not limited to, diskettes, CDs, DVDs, USB flash drives, laptops, PDAs, Blackberrys, cell phones, portable audio/video devices (such as iPODs, and MP3 and MP4 players), and personal organizers.

11. Otherwise, not re-disclose Covered Entity PHI except as permitted by applicable law.

12. Be liable to Covered Entity for any damages, penalties and/or fines assessed against Covered Entity should Covered Entity be found in violation of the HIPAA Privacy Rule due to Business Associate's material breach of this section. Covered Entity is authorized to recoup any and all such damages, penalties and/or fines assessed against Covered Entity by means of withholding and/or offsetting such damages, penalties, and/or fines against any and all sums of money for which Covered Entity may be obligated to the Business Associate under any previous contract and/or this or future contracts. In the event there is no previous contractual relationship between the Business Associate and Covered Entity, the amount to cover such damages, penalties and/or fines shall be due from Business Associate immediately upon notice.

D. Permitted Uses and Disclosures by Business Associate

1. Except as limited in the Contract, Business Associate may use PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use would not violate the Privacy Rule if done by Covered Entity or Covered Entity's privacy practices. Unless otherwise permitted in this Agreement, in the Contract or required by law, Business Associate may not disclose/re-disclose PHI except to Covered Entity.

2. Except as limited in this Agreement, Business Associate may use/disclose PHI for internal management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, as needed for Business Associate to provide its services under the Contract.

3. Except as limited in this Agreement, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).

4. Business Associate may use PHI to report violations to appropriate Federal or State authorities as permitted by § 164.502(j)(1).

E. Covered Entity Provisions

Covered Entity agrees to:

1. Notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

2. Notify Business Associate of any changes in, or revocation of, permission by individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

3. Notify Business Associate of any restriction to the use/disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use/disclosure of PHI.

4. Not request Business Associate to use/disclose PHI in any manner not permitted under the Privacy Rule if done by Covered Entity.

F. Term and Termination

1. The terms of this Agreement shall be effective immediately upon signing of both the Contract and this Agreement, and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is returned to Covered Entity, or,

if it is infeasible to return PHI, protections are extended to such PHI in accordance with the termination provisions in this Section.

a. Upon its knowledge of a material breach by Business Associate, Covered Entity shall either: Allow Business Associate to cure the breach or end the violation and terminate the Contract if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; or
b. Immediately terminate the Contract if Business Associate has breached a material term of this Agreement and cure is not possible; or
c. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

2. Effect of Termination

a. Except as provided in paragraph (b) below, upon termination of the Contract, Business Associate shall return all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision also applies to PHI in the possession of Business Associate's contractors or agents. Business Associate shall retain no copies of the PHI.
b. If Business Associate determines that returning the PHI is infeasible, Business Associate shall notify Covered Entity of the conditions that make return infeasible. Upon mutual agreement of the parties that return of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return infeasible, for so long as Business Associate maintains such PHI.

G. Security Compliance

Business Associate agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Covered Entity, and will require that its agents and contractors to whom it provides such information do the same. Further, Business Associate agrees to comply with Covered Entity's security policies and procedures. Business Associate also agrees to provide Covered Entity with access to and information concerning Business Associate's security and confidentiality policies, processes, and practices that affect electronic PHI provided to or created by Business Associate pursuant to the Agreement upon reasonable request of the Covered Entity. Covered Entity shall determine if Business Associate's security and confidentiality practices, policies, and processes comply with HIPAA and all regulations promulgated under HIPAA. Additionally, Business Associate will immediately report to Covered Entity any Security Incident of which it becomes aware.

H. Miscellaneous

1. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.

2. The Parties agree to amend this Agreement as necessary to comply with HIPAA and other applicable law.

3. The respective rights and obligations of Business Associate under **§ F. 3** shall survive the termination of the Contract.

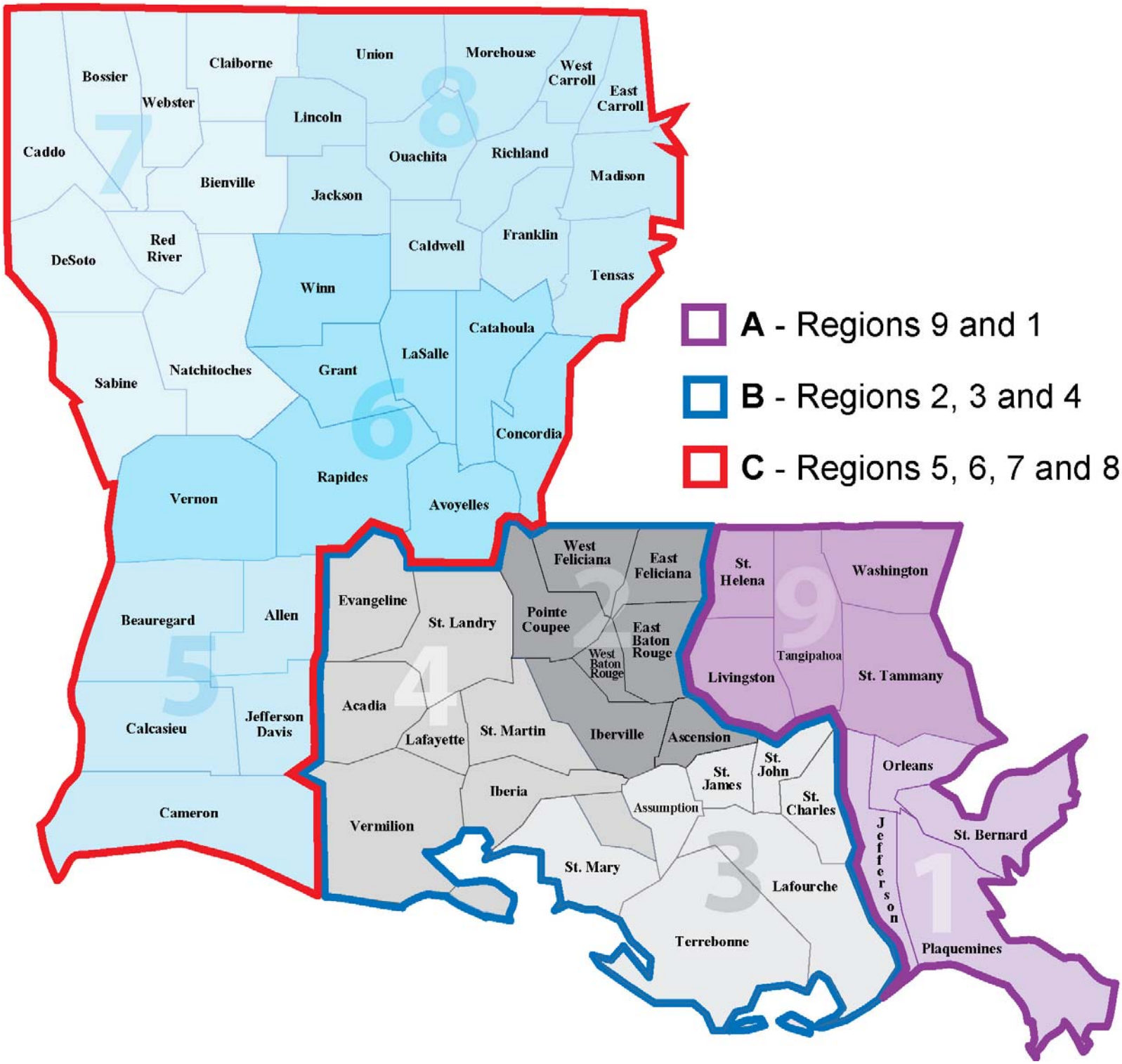
4. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

_____	_____
CCN Provider Representative	DHH Representative
Title:_____	Title:_____
Please print Name:_____	Please print Name:_____
Date:_____	Date:_____

Appendix D

Geographic Services Area Map

Proposed CCN Implementation by Regions



Appendix E

Mercer Certification, Rate Development Methodology and Rates

F. Ronald Ogborne III, FSA, CERA, MAAA
Principal

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Ms. Ruth Kennedy
Medicaid CCN Director
Louisiana Department of Health and Hospitals
Bienville Building
628 North 4th Street – 7th Floor
Baton Rouge, LA 70802

April 8, 2011

Subject: Enhanced Primary Care Case Management fee estimate methodology

Dear Ms. Kennedy:

In partnership with the State of Louisiana (State), Mercer Government Human Services Consulting (Mercer) developed estimates of the total enhanced Primary Care Case Management (ePCCM) fees for the Coordinated Care Network – Shared Savings (CCN-S) program being developed by the State for the period of January 1, 2012 to December 31, 2012. This letter presents an overview of the analyses and methodology used to develop these total ePCCM fee estimates.

The total ePCCM fee that will be paid by the State to the CCN-S entities on a per-member-per-month (PMPM) basis consists of two components:

- A primary care provider (PCP) care management fee for care management services provided directly by a PCP for each member to whom they are linked
- An enhanced primary care management fee for all other services provided by the CCN-S under the Contract

The State has independently established $1.50 as the PCP care management fee for all CCN-S participants based on historical experience from the CommunityCare 2.0 program.

The enhanced primary care management fee component was developed by Mercer and is the focus of this letter. This fee component will be dependent upon the Medicaid eligibility category of each enrollee and will be subject, in aggregate, to a reconciliation of the savings achieved under the program.

All assumptions underlying the total ePCCM fee estimates presented in this document have been developed based on the specifications outlined in the proposed Notice of Intent. To the extent that significant changes are made to the program, these total ePCCM fee estimates may need to be adjusted accordingly.

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Program overview

The CCN-S model will function as a State Plan program whereby PCPs join with a CCN-S, the ePCCM entity, to create a formal and distinct network of PCPs to coordinate the full continuum of care while achieving budget and performance goals and benchmarks.

Through contractual arrangements with the State, the CCN-S entities and their PCPs will provide the State with the ability to ensure accountability while improving access, coordinating care and promoting healthier outcomes.

Eligibility

The following eligibility groups of Medicaid recipients are required to enroll in a CCN-S on a mandatory basis unless they meet any of the conditions for exclusion from participation:

- Temporary Assistance for Needy Families (TANF) and TANF-related recipients
- LaCHIP recipients
- Pregnant Women
- Breast and Cervical Cancer Program participants
- Aged, Blind and Disabled Individuals age 19 or older

The following groups of Medicaid recipients will be allowed to participate in a CCN on a voluntary basis, but will not be required to do so:

- Supplemental Security Income (SSI) or Disability Medicaid Program recipients under age 19
- Indians who are members of federally recognized tribes
- Children with special health care needs
- Children in foster care or other out-of-home placement or receiving adoption assistance

Medicaid recipients in either a mandatory or voluntary enrollment group who meet one or more of the following conditions are excluded from participation in a CCN:

- Individuals residing in a nursing facility or intermediate care facility for the developmentally disabled
- Individuals receiving hospice services
- Individuals with Medicare coverage
- Individuals who are receiving services through the Tuberculosis Infected Individuals Program
- Individuals receiving services through a 1915(c) waiver
- Individuals under the age of 21 who are listed on the New Opportunities Waiver Registry
- Individuals enrolled in the Program of All-Inclusive Care for the Elderly

- Individuals with a limited eligibility period including Spend-down Medically Needy Program and Emergency Services Only participants
- Individuals enrolled in the LaCHIP Affordable Plan Program
- Individuals enrolled in the Take Charge Program

Covered services

The CCN-S entities must demonstrate the capacity to manage targeted populations through:

- Care Management
- Care Coordination
- Utilization Management and Prior Authorization
- Case Management
- Chronic Care Management
- Quality Management
- Customer Service

The CCN-S entities must meet all the requirements outlined in the Request for Proposal/Contract, including, but not limited to, care management (e.g. quality, utilization management, case management, care coordination), provider monitoring and reporting.

The enhanced primary care management fee component of the total ePCCM fee is payment-in-full for these services, with the exception of any payments associated with the savings reconciliation. Claims for medical treatment or diagnostic services will continue to be paid by the State on a fee-for-service basis.

Enhanced primary care management fee range development

Data sources

In support of the development of the enhanced primary care management fee estimates, Mercer relied upon the following data sources:

- PayMonitor® database of employee salaries by job type
- State enrollment projections for potential CCN-S entities

Additionally, Mercer relied upon their experience in working with PCCM, Disease Management and Medical Home Initiatives for other state Medicaid programs, as well as the expertise of Mercer clinicians familiar with the operation of similar programs in other populations.

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Enrollment assumptions

In order to develop enhanced primary care management fee component estimates, it was necessary to make assumptions regarding the enrollment levels of prospective CCN-S entities. As specified in the Request for Proposal, each entity shall have the capacity to enroll a minimum of 75,000 participants. For the calendar year (CY) 2012 contract period, however, the State is anticipating that prospective CCN-S entities will enroll approximately 30,000 participants on average.

Based on the available information and experiences observed in similar programs, Mercer selected enrollment assumptions for this analysis that reflected a balance of the following factors:

- Expected CCN-S enrollment levels during the contract period
- Potential challenges associated with bringing a new program or entity to operational readiness
- Realistic expectations for the economies of scale and management efficiencies that a well-managed CCN-S should be able to achieve

To the extent that actual enrollment patterns vary from these assumptions, the State may wish to revise this analysis and the resulting fee estimates accordingly.

Fee components

Based on the requirements outlined in the Contract, program costs were classified into the following seven components:

- Prior Authorization
- Patient Centered Medical Home
- Care Coordination
- Case Management and Chronic Care Management
- Customer Service
- Provider Monitoring and Services
- Quality Management and Compliance Monitoring

Each component was further divided into fixed and variable costs and total costs were estimated using a staffing and salary requirements and/or annual budget approach. In some cases, both methods were applied to different elements within the same component.

Staffing and salary requirements approach

Under the staffing and salary requirements approach, Mercer relied on specified staffing requirements and clinical expertise in conjunction with enrollment assumptions to develop estimates of the number of full time employees a well-managed CCN-S entity would need to employ to fulfill their obligations under the Contract. Once appropriate staffing levels were estimated, salary

requirements for each type of employee were used to estimate the cost of a particular component or subcomponent. Average yearly cash compensation levels for each position type were estimated based on Mercer's PayMonitor® and include provisions for the cost of additional benefits, such as medical insurance and retirement benefits, to compute the total compensation.

The number of employees and the total annual compensation levels were combined to produce total projected cost estimates.

Annual budget approach

Projected costs for a small subset of subcomponents were estimated using the annual budget approach. For these functions and duties, Mercer relied on its experience in working with similar programs and market research to develop annual budget estimates for the tasks required by the Contract.

Variation in fee components estimates by population

In accordance with the Contract, the State will pay distinct enhanced primary care case management fees for TANF/LaCHIP-related and SSI-related enrollees. As such, estimates of the enhanced primary care management fee component have been developed for each population. For the Patient-Centered Medical Home, Care Coordination; Customer Service, Provider Monitoring and Services, and Quality Management and Compliance Monitoring tasks within the enhanced primary care management fee component, CCN-S entity costs are not expected to vary significantly based on the relative acuity of the population being served.

For the remaining components (i.e., Prior Authorization and Case Management and Chronic Care Management), however, staffing ratios for subcomponents related to specific functions, such as claims review, or that involve direct interaction with enrollees were adjusted to reflect differences in the prevalence of chronic diseases and the overall level healthcare needs between the two populations. The adjustments were developed based on a review of relevant literature, prevalence rates in similar populations in other states and the expertise of Mercer's clinicians.

All cost projections were reviewed for reasonableness both individually and in total by Mercer clinicians with experience in operating similar programs.

Account management and overhead

To provide ePCCM services, there are account management and overhead costs that each CCN-S entity must incur in addition to the components described above. These costs include, but are not limited to, facility costs, hardware and software costs and the cost of capital.

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Such costs are typically proportional to the total number of full time employees and/or the total operational cost of an entity. Provisions for account management and overhead costs were estimated based on experience observed in similar programs in other states and were reviewed for reasonableness by Mercer clinicians.

Enhanced primary care management fee estimates

The estimates of the enhanced primary care management fees, developed by Mercer in consultation with the State, are comprised of the seven fee components plus account management and overhead costs. They are designed to be paid for each CCN-S enrollee, regardless of which services they use. The PMPM enhanced primary care management fee estimates for each population for the CY 2012 contract period are summarized in the table below:

Enhanced primary care management fee estimates	TANF/LaCHIP-related populations	SSI-related populations
Prior Authorization	$ 1.48	$ 2.28
Patient Centered Medical Home	$ 1.12	$ 1.12
Care Coordination	$ 0.49	$ 0.49
Case Management and Chronic Care Management	$ 2.02	$ 5.90
Customer Service	$ 0.45	$ 0.45
Provider Monitoring and Service	$ 0.53	$ 0.53
Quality Management and Compliance Monitoring	$ 2.60	$ 2.60
Account Management and Overhead	$ 3.12	$ 4.79
Total enhanced primary care management fee	$ 11.81	$ 18.16

Please note that the cost projections made by Mercer in the development of the above fees include the allocation of certain costs across more than one of the seven components. Therefore, the removal of any of the seven components from the services in the Request for Proposal/Contract would require recalculation of the rates. The effect of the removal of a component is not necessarily the amount shown for that component in the above table.

Savings reconciliation

It is the expectation of the State that the CCN-S model, with its additional fees, will achieve savings relative to the aggregate Per Capita Prepaid Benchmark (PCPB). To ensure the CCN-S entities are held financially accountable, the State has established a savings determination process as a part of the CCN-S contract for CY 2012.

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The State will periodically compare the actual aggregate cost of authorized services as specified in CCN-S Request for Proposal/Contract, including the enhanced primary care case management fee for dates of services in the reconciliation period, to the aggregate PCPB. The PCPB will not include the PCP care management fees.

In the event that a CCN-S entity exceeds the Per Capita Prepaid Benchmark in the aggregate, the CCN-S entity will be required to refund up to 50% of the total amount of the enhanced primary care case management fees paid to the CCN during the reconciliation period. Conversely, CCN-S entities will be eligible for up to 60% of savings if the actual aggregate costs of authorized services, including enhanced primary care case management fees, are less than the aggregate PCPB. Due to limitations under the Medicaid State Plan preprint for section for section 1932(a) State Plan amendments, shared savings will be limited to 5% of the actual aggregate costs including the enhanced primary care case management fees paid.

Total ePCCM fee estimates

The estimates of the total ePCCM fees consist of the estimates of the enhanced primary care management fees plus the PCP care management fee. The estimates of the total ePCCM fees for each population on a PMPM basis for the CY 2012 contract period are summarized in the table below:

Total ePCCM fee estimates	TANF/LaCHIP-related populations	SSI-related populations
Enhanced primary care management fee	$ 11.81	$ 18.16
PCP care management fee	$ 1.50	$ 1.50
Total enhanced Primary Care Case Management fee	$ 13.31	$ 19.66

In preparing these estimates of the ePCCM fees, Mercer has used and relied upon eligibility and program design data and information supplied by the State. The State is responsible for the validity and completeness of the supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we have not audited it. In our opinion, it is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

The ePCCM fee estimates developed by Mercer are actuarial projections of future contingent events. Actual costs for CCN-S entities will differ from these projections due to factors including, but not limited to differences in business models and management techniques, the geographic area(s) in which an entity chooses to operate, the specific needs of an entity's enrollees and the efficiencies and economies of scale that an entity is able to achieve. As such, these estimates should be

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interpreted as having a likely range of variability. Furthermore, as noted above, significant variation between emerging experience and key assumptions underlying these fee estimates may warrant the State to revise this report accordingly.

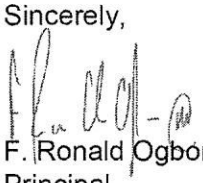
Mercer has developed estimates of the ePCCM fees on behalf of and in consultation with the State to support on-going program design decisions. Use of these enhanced primary care management fee estimates for any purpose beyond that stated may not be appropriate.

Potential CCN-S entities are advised that the use of these ePCCM fee estimates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these enhanced primary care management fee estimates by potential CCN-S entities for any purpose. Mercer recommends that any organization considering contracting with the State should analyze its own projected expenses and any other costs for comparison to the rates offered by the State before deciding whether to contract with the State.

This methodology letter assumes the reader is familiar with the CCN-S program, Medicaid eligibility rules and actuarial rating techniques. It is intended for the State and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals to understand the technical nature of these results. This document should only be reviewed in its entirety.

If you have any questions, please feel free to contact me at +1 602 522 6595 or Robert Butler at +1 850 294 9669.

Sincerely,



F. Ronald Ogborne III, FSA, CERA, MAAA
Principal

RO/hl

Copy:
Maddie McAndrew, State
Robert Butler, Mercer
Jennie Echols, Mercer

Appendix F

CCN-S Benchmark Summary

Nicholas J. Simmons, FIA, FSA, MAAA
Principal

Sudha Shenoy, FSA, MAAA, CERA
Principal

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Ms. Ruth Kennedy
Deputy Director of Medicaid
Louisiana Department of Health and Hospitals
628 North 4th Street
Baton Rouge, LA 70821

April 8, 2011

Subject: Louisiana Coordinated Care Networks – Shared Savings Model (CCN-S) Program Benchmark Development for Contract Periods ending December 31, 2012

Dear Ruth:

The Louisiana Department of Health and Hospitals (DHH) contracted with Mercer Government Human Services Consulting (Mercer) to develop benchmark costs for the purpose of measuring savings achieved by Shared Savings Model Coordinated Care Networks (CCN-S) covering contract periods from program startup, which varies by geographical area, through December 31, 2012. The CCN-S program will be implemented in 3 phases and the benchmarks for each phase will be effective through December 31, 2012. The regions implemented in each phase are as follows:

Phase 1 (January 1, 2012 through December 31, 2012)
- New Orleans
- North Shore (formerly known as Mandeville)

Phase 2 (March 1, 2012 through December 31, 2012)
- Baton Rouge
- Thibodaux
- Lafayette

Phase 3 (May 1, 2012 through December 31, 2012)
- Lake Charles
- Alexandria
- Shreveport
- Monroe

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Page 2
April 8, 2011
Ms. Ruth Kennedy
Louisiana Department of Health and Hospitals

This letter presents an overview of the methodology used in Mercer's benchmark development process. Although there are no specific requirements of the Centers for Medicare and Medicaid Services (CMS) concerning benchmark development, nor any requirement that the benchmarks be actuarially certified, we anticipate that CMS will have a significant interest in understanding how the benchmarks were developed. This rate development process was based on Medicaid fee-for-service (FFS) medical claims and resulted in development of a single set of proposed benchmarks for each region and rate cell combination which are attached to this letter.

Rate Methodology

Overview

Benchmark costs for the CCN-S program were developed in an actuarially sound manner. Where parallels can be drawn to the rate-setting guidelines established by CMS, we used consistent approaches and methods wherever this could appropriately be done. One of the key considerations was the base data. Mercer worked with DHH to obtain Medicaid FFS data from State Fiscal Year (SFY) 2009 and SFY 2010. Louisiana's SFY runs from July 1st through June 30th of the following year. Restrictions were applied to the enrollment and FFS claims data so that it matched the populations and benefit package defined in the Contract.

To develop benchmarks, adjustments were applied to the base data. These adjustments were all consistent with those provided for in capitated rate development under the CMS Capitated Rate-Setting Checklist:

- removal of enrollment and claims during periods of retroactive eligibility;
- completion factors to account for unpaid claims at the time of the data submission;
- adjustment to reflect amounts paid outside of the Louisiana Medicaid Management Information System (MMIS), including but not limited to inpatient outlier stays, inpatient and outpatient cost reconciliations, fraud and abuse recoupments;
- trend factors to forecast the expenditures and utilization to the appropriate contract period;
- prospective and historic program changes not reflected in the base data;
- prescription drug rebates; and
- data smoothing.

The GME component of teaching hospital per diems were not removed from the cost basis so as to develop a benchmark appropriate for reconciling against CCN-S costs that will include

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inpatient cost including the GME element of the per diems. Since the costs coordinated by the CCN-S will be paid using FFS Medicaid rates, the per diems paid will include exactly the same GME amounts as in the Louisiana Medicaid State Plan.

Using prescription drug costs net of rebates in both benchmark and actual costs guards against sharing too large of a saving but does suggest that benchmarks be updated in the event of any material changes in the State's rebate structure or results.

Since DHH will not include costs over $100,000 per year for any recipient in the reconciliation, an appropriate adjustment was made to the benchmark costs.

The resulting benchmarks were expressed as PMPM amounts by rate cell. Risk adjustment will be applied to the resulting targets in a manner comparable to that to be used for CCN-P rates to account for health risk differences between the various CCN-S and between the CCN-S as a group and the CCN-P networks. This will allow for any selection for or against each of the models.

Base Data Development

Mercer was provided with Medicaid FFS enrollment and claims data from SFY09 and SFY10 with runout through August 2010. Mercer was also provided with supplemental data files containing information on outlier claims paid outside of the MMIS system, fraud and abuse recoupments, prescription drug rebates, and Inpatient and Outpatient hospital cost settlements. These payments/recoupments outside of the MMIS system have been added to or subtracted from the base claims data as appropriate so that the relevant cost for the population eligible for enrollment in the CCN-S program is replicated.

Mercer reviewed the data for consistency and reasonableness and determined that the data appears appropriate for the purpose of setting benchmarks for the CCN-S program.

Enrollment Data

The enrollment file supplied by DHH's fiscal agent provided all enrollment records for each member for each month. Therefore, if a member's eligibility status was retroactively changed, both the old and the new records were present. Most often this occurred because a recipient was retroactively categorized as SSI from Family and Children. In this case, the enrollment file would have included both the SSI enrollment record and the Family and Children record for the

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same month. Mercer worked with DHH to develop a hierarchy to determine which was the appropriate unique enrollment record to use – typically the SSI record.

Claims Data

Mercer used fiscal year July 1, 2008 through June 30, 2009 (SFY09) and July 1, 2009 through June 30, 2010 (SFY10) fee-for-service (FFS) data as the data source. The FFS data reflects the actual medical expenses to DHH of providing healthcare coverage for the CCN-S eligible population. The expenses are net Third Party Liability and subrogation. Mercer reviewed the FFS data to ensure it appeared reasonable and appropriate but did not audit the data. Specifically, Mercer reviewed the following issues:

- completeness and consistency of incurred claims over time;
- consistency between FFS claims data and DHH published reports;
- all payments outside of the MMIS claims system appeared to be properly accounted for; and
- the data appeared to have been properly restricted to those services and populations to be covered under the CCN-S program.

Adjustments were made to the FFS data to reflect the complete cost of an actuarially equivalent population for the CCN-S contract. The most significant adjustments are discussed below. In each case, the adjustments were calculated and applied at the rate cell level. The discussion below summarizes the overall impact of each adjustment expressed as a percentage of the total program cost.

Outlier Claims for Children Under 6 Years – DHH makes payments for outlier claims incurred during an Inpatient admission for children under 6 years old outside of the MMIS. Adding outlier claims to the base data resulted in an increase to cost of 1.95% in SFY09 and 1.93% in SFY10. The cost of outlier claims has been reflected in the databook Mercer has prepared for the CCNs.

Incurred-but-not-Reported Claims Adjustments – Mercer estimated and adjusted for the remaining liability associated with incurred-but-not-reported claims for SFY09 and SFY10. The overall adjustments for SFY09 and SFY10 using paid claims data through August 2010 were -0.14% and 2.42% respectively.

Fraud-and-Abuse Recoupments – Adjustments were made for recoupments due to fraud-and-abuse recoveries. Those adjustments were -0.10% in SFY09 and -0.10% in SFY10.

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Graduate Medical Education (GME) – Hospital per diem rates used to make payments for care coordinated by the CCN-S networks include the same GME elements as under the state plan. No adjustment was therefore needed.

Pharmacy Rebates – Adjustments were made to reflect pharmacy rebates. The overall adjustments were -9.23% in SFY09 and -9.46% in SFY10.

Inpatient, Outpatient Hospital Cost Settlements, and Supplemental Payments to High Medicaid Community Hospitals – LSU state hospitals and outpatient hospitals receive settlements based on cost reports. Certain "High Medicaid Community Hospitals" also receive supplemental payments that are provided for in the State plan. Mercer applied adjustments of 2.96% in SFY09 and 1.07% in SFY10 to capture the impact of cost settlements made outside of the MMIS.

Retroactive eligibility – Individuals will not enroll with a CCN-S until Medicaid eligible. Even after receiving Medicaid eligibility, it may take 30 days to become enrolled in a CCN. Therefore, enrollment and claims incurred during the retroactive period and those during the first month of Medicaid eligibility have been removed from our calculations. Infants are an exception because they will be covered under the mother's plan from the date of birth.

Non-covered populations – In general, the CCN-S program includes individuals classified as SSI, Family and Children, Foster Children and Breast and Cervical Cancer. The following individuals are excluded from participation in the CCN-S program:

- Medicare Dually Eligible Individuals
- Home and Community Based Services Waiver Recipients
- *Chisholm* Class Members
- Individuals Receiving Medicaid Hospice Services
- Individuals Residing in Long Term Care Facilities (Nursing Home, ICF/DD)
- Individuals Receiving Services for Three Months or Less (Medically Needy Spend-down)
- Undocumented Immigrants Eligible for Emergency Services Only
- Enrollees receiving single service (family planning only)
- LaCHIP Affordable Plan

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Non-covered services – The CCN-S rates are based on services covered under the provider agreement. The following services have been excluded in the determination of the benchmarks:

- Specified Services provided through DHH's Early-Steps Program
- Dental Services
- ICF/DD Services
- Hospice
- Personal Care Services (EPSDT and LT-PCS)
- Nursing Facility Services
- School-based Individualized Education Plan Services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures
- Home and Community-Based Waiver Services
- Specialized Behavioral Health Services (e.g. mental health rehabilitation)
- Targeted Case Management Services
- Durable Medical Equipment (DME)
- Orthotics and Prosthetics
- Non-emergency transportation
- Specialized Behavioral Health drugs

Client participation amounts – Costs associated with "spenddown" and post-eligibility treatment of income are not included in the base data.

Third-Party Liability – Recoveries associated with Third Party Liability and subrogation have been removed from claims.

DSH Payments – DSH payments are made outside of the MMIS system and have not been included in the benchmarks. These payments will continue to be made after implementation of the CCN-S program.

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Co-payments – Co-pays are only applicable to prescription drugs. Since co-pays will remain in place unchanged, no adjustment is necessary.

Primary Case Care Management (PCCM) Fee – Historically, Louisiana has paid a PCCM fee for members assigned to a primary care provider under the PCCM program. This portion of the case management fee paid to the CCN-S networks will be required to be passed through to primary care providers so no adjustment is needed.

PMPM Category Groupings

Benchmarks are developed using PMPM amounts that vary by the major categories of eligibility. Furthermore, where appropriate, the PMPMs within a particular category of eligibility are subdivided into different age and gender bands to reflect differences in risk due to age and gender and during child bearing ages. In addition, due to the high cost associated with pregnancies, DHH will include a maternity cost allowance in the benchmark for each delivery that takes place (kick allowance). The following is a list of the different PMPM cells for each eligibility category including the maternity kick allowance.

SSI	
▪ 0 – 2 Months, Male and Female ▪ 3 – 11 Months, Male and Female ▪ 1 – 5 Years, Male and Female ▪ 6 – 13 Years, Male and Female	▪ 14 – 18 Years, Male and Female ▪ 19 – 44 Years, Male and Female ▪ 45+ Years, Male and Female
Family & Children	
▪ 0 – 2 Months, Male and Female ▪ 3 – 11 Months, Male and Female ▪ 1 – 5 Years, Male and Female ▪ 6 – 13 Years, Male and Female ▪ 14 – 18 Years, Female	▪ 14 – 18 Years, Male ▪ 19 – 44 Years, Female ▪ 19 – 44 Years, Male ▪ 45+ Years, Female ▪ 45+ Years, Male
Foster Care Children, All Ages	Breast and Cervical Cancer, All Ages
Maternity Kick Allowance	

Trend Development

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the expenses of providing health

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care services in a future period. Mercer reviewed a variety of sources to develop the trend assumptions. These sources included, but were not limited to:

- health care economic indices such as Consumer Price Index for the South-Atlantic region;
- Mercer's regression analysis applied to trends exhibited in the FFS claims data;
- trends in other State Medicaid programs for similar populations; and
- judgment regarding economic outlook balancing a variety of sources.

Mercer developed individual trends for each category of eligibility and service category. Mercer's target trend can be found in the following table.

COA Description	COS Description	Utilization	Unit Cost	PMPM Trend
SSI	Inpatient Hospital	1.77%	0.00%	1.77%
SSI	Outpatient Hospital	7.77%	2.54%	10.51%
SSI	Primary Care Physician	3.77%	0.00%	3.77%
SSI	Specialty Care Physician	3.77%	0.00%	3.77%
SSI	FQHC/RHC	3.77%	0.00%	3.77%
SSI	EPSDT	3.77%	0.00%	3.77%
SSI	Certified Nurse Practitioners/Clinical Nurse	3.77%	0.00%	3.77%
SSI	Lab/Radiology	5.51%	0.00%	5.51%
SSI	Home Health	5.51%	0.00%	5.51%
SSI	Emergency Transportation	2.51%	0.00%	2.51%
SSI	Rehabilitation Services (OT, PT, ST)	5.51%	0.00%	5.51%
SSI	Clinic	3.77%	0.00%	3.77%
SSI	Family Planning	3.77%	0.00%	3.77%
SSI	Other	5.51%	0.00%	5.51%
SSI	Prescribed Drugs	1.77%	0.00%	1.77%
SSI	Emergency Room	7.77%	2.54%	10.51%
SSI	Basic Behavioral Health	3.77%	0.00%	3.77%
Family and Children	Inpatient Hospital	1.51%	0.00%	1.51%
Family and Children	Outpatient Hospital	5.51%	2.53%	8.18%
Family and Children	Primary Care Physician	3.51%	0.00%	3.51%
Family and Children	Specialty Care Physician	3.51%	0.00%	3.51%
Family and Children	FQHC/RHC	3.51%	0.00%	3.51%
Family and Children	EPSDT	3.51%	0.00%	3.51%

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Louisiana Department of Health and Hospitals

COA Description	COS Description	Utilization	Unit Cost	PMPM Trend
Family and Children	Certified Nurse Practitioners/Clinical Nurse	3.51%	0.00%	3.51%
Family and Children	Lab/Radiology	5.51%	0.00%	5.51%
Family and Children	Home Health	5.51%	0.00%	5.51%
Family and Children	Emergency Transportation	2.51%	0.00%	2.51%
Family and Children	Rehabilitation Services (OT, PT, ST)	5.51%	0.00%	5.51%
Family and Children	Clinic	3.51%	0.00%	3.51%
Family and Children	Family Planning	3.51%	0.00%	3.51%
Family and Children	Other	5.51%	0.00%	5.51%
Family and Children	Prescribed Drugs	2.51%	0.00%	2.51%
Family and Children	Emergency Room	5.51%	2.53%	8.18%
Family and Children	Basic Behavioral Health	3.51%	0.00%	3.51%
Foster Care Children	Inpatient Hospital	1.77%	0.00%	1.77%
Foster Care Children	Outpatient Hospital	7.77%	2.55%	10.51%
Foster Care Children	Primary Care Physician	3.77%	0.00%	3.77%
Foster Care Children	Specialty Care Physician	3.77%	0.00%	3.77%
Foster Care Children	FQHC/RHC	3.77%	0.00%	3.77%
Foster Care Children	EPSDT	3.77%	0.00%	3.77%
Foster Care Children	Certified Nurse Practitioners/Clinical Nurse	3.77%	0.00%	3.77%
Foster Care Children	Lab/Radiology	5.51%	0.00%	5.51%
Foster Care Children	Home Health	5.51%	0.00%	5.51%
Foster Care Children	Emergency Transportation	2.51%	0.00%	2.51%
Foster Care Children	Rehabilitation Services (OT, PT, ST)	5.51%	0.00%	5.51%
Foster Care Children	Clinic	3.77%	0.00%	3.77%
Foster Care Children	Family Planning	3.77%	0.00%	3.77%
Foster Care Children	Other	5.51%	0.00%	5.51%
Foster Care Children	Prescribed Drugs	1.77%	0.00%	1.77%
Foster Care Children	Emergency Room	7.77%	2.54%	10.51%
Foster Care Children	Basic Behavioral Health	3.77%	0.00%	3.77%
Breast and Cervical Cancer	Inpatient Hospital	1.77%	0.00%	1.77%
Breast and Cervical Cancer	Outpatient Hospital	7.77%	2.55%	10.51%
Breast and Cervical Cancer	Primary Care Physician	3.77%	0.00%	3.77%
Breast and Cervical Cancer	Specialty Care Physician	3.77%	0.00%	3.77%
Breast and Cervical Cancer	FQHC/RHC	3.77%	0.00%	3.77%
Breast and Cervical Cancer	EPSDT	3.77%	0.00%	3.77%

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COA Description	COS Description	Utilization	Unit Cost	PMPM Trend
Breast and Cervical Cancer	Certified Nurse Practitioners/Clinical Nurse	3.77%	0.00%	3.77%
Breast and Cervical Cancer	Lab/Radiology	5.51%	0.00%	5.51%
Breast and Cervical Cancer	Home Health	5.51%	0.00%	5.51%
Breast and Cervical Cancer	Emergency Transportation	2.51%	0.00%	2.51%
Breast and Cervical Cancer	Rehabilitation Services (OT, PT, ST)	5.51%	0.00%	5.51%
Breast and Cervical Cancer	Clinic	3.77%	0.00%	3.77%
Breast and Cervical Cancer	Family Planning	3.77%	0.00%	3.77%
Breast and Cervical Cancer	Other	5.51%	0.00%	5.51%
Breast and Cervical Cancer	Prescribed Drugs	1.77%	0.00%	1.77%
Breast and Cervical Cancer	Emergency Room	7.77%	2.54%	10.51%
Breast and Cervical Cancer	Basic Behavioral Health	3.77%	0.00%	3.77%
Maternity Kickpayment	Maternity Kickpayment	0.00%	0.00%	0.00%

The overall annualized PMPM trend assumption for the CCN-S program is 3.39%.

Programmatic Changes/Rate Issues

Programmatic change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base year. Mercer applied programmatic change adjustments to incorporate factors not fully reflected in the base data. These adjustments were mutually exclusive and made only once in the benchmark setting process.

Changes to Inpatient Hospital Reimbursement – Various changes have been made to hospital per diem rates. Most recently, effective for dates of service on or after January 1, 2011, the inpatient per diem rates paid to non-State and non-Rural hospitals were reduced by 2 percent of the per diem rate on file as of December 31, 2010. The rural and state hospitals have been excluded from the rate reductions. The per diem rates for state hospitals have increased significantly since the base data period however this primarily affects the relative weights of the per diems versus cost settlements and has little impact on the total payment.

Changes to the Laboratory/Radiology Fee Schedule – There have been various changes to fee schedules. Most recently, effective for dates of service on or after January 1, 2011, the reimbursement rates for laboratory services was reduced by 2 percent of the fee amounts on file as of December 31, 2010.

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Outpatient Hospital Fee Schedule Changes

Children's Specialty Hospital

Effective for dates of service on or after January 1, 2011, the reimbursement paid to Children's Specialty Hospitals for outpatient surgery is reduced by 2 percent of the fee schedule on file as of December 31, 2010.

From July 1, 2008 through February 19, 2009, Children's Specialty Hospitals were cost settled at 86.20% of cost. From February 20, 2009 through August 3, 2009, these hospitals were cost settled at 83.18% of cost. From August 4, 2009 through August 31, 2009, these hospitals were cost settled at 78.48% of cost. From September 1, 2009 through February 2, 2010, these hospitals were cost settled at 97.00% of cost. From February 3, 2010 through July 31, 2010, these hospitals were cost settled at 92.15% of cost. Reimbursement going forward of 87.91% (August 1, 2010 – December 31, 2010) of allowable cost as calculated through the cost report settlement process will be reduced by 2%, making final reimbursement 86.15% (January 1, 2011 going forward).

Non-State and Non-Rural Outpatient Hospitals

Again, there have been various changes to fee schedules. Most recently, effective for dates of service on or after January 1, 2011, the reimbursement paid to non-rural, non-state hospitals for outpatient surgery was reduced by 2 percent of the fee schedule on file as of December 31, 2010.

From July 1, 2008 through February 19, 2009, Non-Rural and Non-State outpatient hospitals (other than Children's) were cost settled at 86.20% of cost. From February 20, 2009 through August 3, 2009, these hospitals were cost settled at 83.18% of cost. From August 4, 2009 through February 2, 2010, these hospitals were cost settled at 78.48% of cost. From February 3, 2010 through July 31, 2010, these hospitals were cost settled at 74.56% of cost. Reimbursement going forward of 71.13% (August 1, 2010 – December 31, 2010) of allowable cost as calculated through the cost report settlement process will be reduced by 2%, making final reimbursement 69.71% (January 1, 2011 going forward).

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Physician Fee Schedule Changes

Members 16 years or older

Effective January 22, 2010, in general, the reimbursement for physician services rendered to recipients 16 years of age or older shall be reduced to 75% of the 2009 Louisiana Medicare Region 99 allowable or billed charges, whichever is lesser amount. Exceptions to the general rule are Prenatal E&M services (99201-99215 w/TH Modifier), Preventive E&M services (99381-99397), and Obstetrical Delivery Services (59400-59622). The Vaginal Delivery Services will be paid at 90% of the 2009 Louisiana Medicare Region 99 allowable or billed charges, whichever is lesser amount.

Members under 16 years

Effective January 22, 2010, the reimbursement for physician services rendered to recipients under 16 years of age shall be reduced to 90% of the 2009 Louisiana Medicare Region 99 allowable or billed charges, whichever is lesser amount. In addition, effective August 1, 2010, DHH is no longer paying an enhanced fee for preventive services for members under 16 years.

Physician Injectibles

Effective January 22, 2010, Physician injectibles are paid at 90% of the 2009 Medicare Average Sale Price (ASP).

Clinical Services-End Stage Renal Disease Facilities Non-Medicare Claims Reimbursement Rate Reduction

Various changes, most recently, effective for dates of service on or after January 1, 2011, the reimbursement to ESRD facilities shall be reduced by 2 percent of the rates in effect on December 31, 2010.

Non-Emergency Medical Transportation – Most recently, effective for dates of service on or after January 1, 2011, the reimbursement rates for non-emergency, non-ambulance medical transportation services shall be reduced by 2 percent of the rates in effect on December 31, 2010.

Emergency Medical Transportation – Most recently, effective on or after January 1, 2011, the reimbursement rates for emergency ambulance transportation services shall be reduced by 2% of the rate on file as of December 31, 2010.

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The compounded effect of all of the fee schedule changes by category of aid and category of service can be found in the table below. Overall, the fee schedule changes since the base data period reduced cost by approximately 6.74% for SFY09 and 4.63% for SFY10.

Data Smoothing

As part of the benchmark development process, Mercer blended data from SFY09 and SFY10 to arrive at the overall data source. The goal of the blending process is to obtain a set of base data that has sufficient credibility and reasonableness to develop appropriate benchmarks. Mercer applied weights of 60% and 40% to the SFY10 and SFY09 data respectively.

Beyond blending data from multiple years, Mercer also used state wide figures where particular PMPM cells within a region had small enrollment. The cost per member per month for a small cell is subject to large fluctuations from one year to the next, thus rendering it less effective at predicting future cost. Using state wide figures results in greater data credibility and reduces the impact of random fluctuations exhibited by the data.

Some categories of eligibility such as the Foster Children and Breast and Cervical Cancer population are too small to have separate PMPM cells due to data credibility concerns. Therefore, state wide figures are used for these populations and the data has been combined across all age and sex cells in determining the benchmark cost.

Risk of Large Claims

To provide protection against the risk of catastrophic claims, the cost for any recipient that is over $100,000 in any year will not be considered in reconciling cost savings for CCN-S plans. The benchmarks have been reduced consistently.

Risk Adjustment

Risk adjustment will be applied to the cost benchmarks in exhibit A to reflect differences in health status of the members served in each plan using the ACG model. The risk adjustment process does not increase or decrease the overall benchmark cost of the program but can change the benchmark for the various CCNs according to the relative risk of their enrolled members, and where the CCN-S networks as a group enroll a more or less costly population than the parallel CCN-P program. Actuarially sound risk adjustment protocols have been developed for this purpose.

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Benchmark Development Overview

To provide additional detail on the benchmark development, Mercer has also provided an overview of the adjustments applied to each PMPM cell in Attachment B. This exhibit presents the breakdown of the assumptions used to calculate the benchmark PMPM.

Actuarial Soundness

In preparing the benchmark PMPMs shown in Attachment A, Mercer has used and relied upon enrollment, FFS claims, reimbursement level, benefit design, and information supplied by the Department of Health and Hospitals (DHH) and its fiscal agent. The DHH and its fiscal agent are responsible for the validity and completeness of this supplied data and information. We have reviewed the data and information for internal consistency and reasonableness but we did not audit it. In our opinion it is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

The benchmark PMPMs in Attachment A were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid covered populations and services under the CCN-S contract.

The benchmarks are actuarial projections of future contingent events. Actual CCN costs will differ from these projections. Mercer has developed these benchmarks on behalf of DHH to form a basis for calculating sharable savings under the CCN-S program. Use of these rate ranges for any purpose beyond that stated may not be appropriate. Furthermore, adjustment should be considered in the event that FFS cost are observed to trend differently than expected during the period leading up to CCN-S implementation such that the benchmarks may become, in retrospect, either excessive or overly difficult to achieve.

CCNs are advised that the use of these benchmarks may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of them by CCNs for any purpose. Mercer recommends that any CCN considering contracting with the DHH should carefully analyze its own projected medical expense before deciding whether to contract with the DHH.

This letter assumes the reader is familiar with the CCN program, Medicaid eligibility rules, and actuarial techniques. It is intended for DHH, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial projections to understand the technical nature of these results.

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If you have any questions on any of the information provided, please feel free to call Nick Simmons at 404 442 3196 and/or Sudha Shenoy at 404 442 3249.

Sincerely,

Nicholas J Simmons, FIA, FSA, MAAA

Sudha Shenoy, FSA, MAAA, CERA

Copy:
Charles "Chip" Carbone - Mercer

Attachment A

CCN-S Benchmark PMPM Summary

				1/1/2012-12/31/2012	
					CCN-S Benchmark PMPM
DHH Administrative Region	Region Description	COA Description	RC Description	FY10 Member Months or Deliveries	PMPM or Cost/Delivery
01	New Orleans	SSI	0-2 Months, Male and Female	218	$ 16,694.19
01	New Orleans	SSI	3-11 Months, Male and Female	1,245	$ 3,611.77
01	New Orleans	SSI	1-5 Years, Male and Female	14,463	$ 639.82
01	New Orleans	SSI	6-13 Years, Male and Female	39,515	$ 202.51
01	New Orleans	SSI	14-18 Years, Male and Female	27,247	$ 215.22
01	New Orleans	SSI	19-44 Years, Male and Female	78,498	$ 506.94
01	New Orleans	SSI	45+ Years, Male and Female	102,751	$ 830.02
01	New Orleans	Family and Children	0-2 Months, Male and Female	33,497	$ 1,299.04
01	New Orleans	Family and Children	3-11 Months, Male and Female	77,569	$ 194.61
01	New Orleans	Family and Children	1-5 Years, Male and Female	445,431	$ 88.04
01	New Orleans	Family and Children	6-13 Years, Male and Female	513,322	$ 56.45
01	New Orleans	Family and Children	14-18 Years, Female	152,761	$ 87.50
01	New Orleans	Family and Children	14-18 Years, Male	137,012	$ 63.97
01	New Orleans	Family and Children	19-44 Years, Female	233,777	$ 189.13
01	New Orleans	Family and Children	19-44 Years, Male	9,515	$ 222.02
01	New Orleans	Family and Children	45+ Years, Female	12,329	$ 365.89
01	New Orleans	Family and Children	45+ Years, Male	3,010	$ 427.14
01	New Orleans	Foster Care Children	Foster Care, All Ages Male & Female	12,787	$ 134.18
01	New Orleans	Breast and Cervical Cancer	BCC, All Ages Female	2,121	$ 1,885.19
01	New Orleans	Maternity Kickpayment	Maternity Kickpayment, All Ages	7,448	$ 6,415.49
09	Mandeville	SSI	0-2 Months, Male and Female	109	$ 16,694.19
09	Mandeville	SSI	3-11 Months, Male and Female	455	$ 3,611.77
09	Mandeville	SSI	1-5 Years, Male and Female	6,506	$ 639.82
09	Mandeville	SSI	6-13 Years, Male and Female	16,269	$ 202.51
09	Mandeville	SSI	14-18 Years, Male and Female	10,589	$ 215.22
09	Mandeville	SSI	19-44 Years, Male and Female	37,522	$ 485.50
09	Mandeville	SSI	45+ Years, Male and Female	55,799	$ 821.90
09	Mandeville	Family and Children	0-2 Months, Male and Female	18,490	$ 1,200.55
09	Mandeville	Family and Children	3-11 Months, Male and Female	43,309	$ 228.93
09	Mandeville	Family and Children	1-5 Years, Male and Female	255,447	$ 108.97
09	Mandeville	Family and Children	6-13 Years, Male and Female	331,543	$ 75.59
09	Mandeville	Family and Children	14-18 Years, Female	91,154	$ 113.29
09	Mandeville	Family and Children	14-18 Years, Male	87,436	$ 81.45
09	Mandeville	Family and Children	19-44 Years, Female	103,701	$ 235.50
09	Mandeville	Family and Children	19-44 Years, Male	7,062	$ 222.02
09	Mandeville	Family and Children	45+ Years, Female	4,435	$ 365.89
09	Mandeville	Family and Children	45+ Years, Male	1,688	$ 427.14
09	Mandeville	Foster Care Children	Foster Care, All Ages Male & Female	19,963	$ 134.18
09	Mandeville	Breast and Cervical Cancer	BCC, All Ages Female	1,934	$ 1,885.19
09	Mandeville	Maternity Kickpayment	Maternity Kickpayment, All Ages	4,195	$ 4,663.96

Attachment A

CCN-S Benchmark PMPM Summary

				3/1/2012-12/31/2012	
					CCN-S Benchmark PMPM
DHH Administrative Region	Region Description	COA Description	RC Description	FY10 Member Months or Deliveries	PMPM or Cost/Delivery
02	Baton Rouge	SSI	0-2 Months, Male and Female	256	$ 16,720.82
02	Baton Rouge	SSI	3-11 Months, Male and Female	1,073	$ 3,618.81
02	Baton Rouge	SSI	1-5 Years, Male and Female	12,818	$ 641.60
02	Baton Rouge	SSI	6-13 Years, Male and Female	27,870	$ 203.12
02	Baton Rouge	SSI	14-18 Years, Male and Female	17,567	$ 215.89
02	Baton Rouge	SSI	19-44 Years, Male and Female	47,779	$ 544.07
02	Baton Rouge	SSI	45+ Years, Male and Female	63,731	$ 788.42
02	Baton Rouge	Family and Children	0-2 Months, Male and Female	25,181	$ 1,339.07
02	Baton Rouge	Family and Children	3-11 Months, Male and Female	56,838	$ 212.99
02	Baton Rouge	Family and Children	1-5 Years, Male and Female	336,041	$ 86.00
02	Baton Rouge	Family and Children	6-13 Years, Male and Female	424,802	$ 55.86
02	Baton Rouge	Family and Children	14-18 Years, Female	119,392	$ 87.93
02	Baton Rouge	Family and Children	14-18 Years, Male	110,422	$ 61.51
02	Baton Rouge	Family and Children	19-44 Years, Female	149,867	$ 197.58
02	Baton Rouge	Family and Children	19-44 Years, Male	5,812	$ 222.78
02	Baton Rouge	Family and Children	45+ Years, Female	7,716	$ 367.09
02	Baton Rouge	Family and Children	45+ Years, Male	1,340	$ 428.45
02	Baton Rouge	Foster Care Children	Foster Care, All Ages Male & Female	10,904	$ 134.63
02	Baton Rouge	Breast and Cervical Cancer	BCC, All Ages Female	1,531	$ 1,893.60
02	Baton Rouge	Maternity Kickpayment	Maternity Kickpayment, All Ages	5,633	$ 4,877.66
03	Thibodaux	SSI	0-2 Months, Male and Female	190	$ 16,720.82
03	Thibodaux	SSI	3-11 Months, Male and Female	577	$ 3,618.81
03	Thibodaux	SSI	1-5 Years, Male and Female	7,824	$ 641.60
03	Thibodaux	SSI	6-13 Years, Male and Female	20,987	$ 203.12
03	Thibodaux	SSI	14-18 Years, Male and Female	12,940	$ 215.89
03	Thibodaux	SSI	19-44 Years, Male and Female	37,213	$ 421.54
03	Thibodaux	SSI	45+ Years, Male and Female	46,801	$ 767.44
03	Thibodaux	Family and Children	0-2 Months, Male and Female	16,509	$ 1,128.38
03	Thibodaux	Family and Children	3-11 Months, Male and Female	37,403	$ 214.42
03	Thibodaux	Family and Children	1-5 Years, Male and Female	213,492	$ 103.77
03	Thibodaux	Family and Children	6-13 Years, Male and Female	267,180	$ 69.18
03	Thibodaux	Family and Children	14-18 Years, Female	79,499	$ 118.90
03	Thibodaux	Family and Children	14-18 Years, Male	73,746	$ 80.66
03	Thibodaux	Family and Children	19-44 Years, Female	100,355	$ 231.26
03	Thibodaux	Family and Children	19-44 Years, Male	5,123	$ 222.78
03	Thibodaux	Family and Children	45+ Years, Female	3,680	$ 367.09
03	Thibodaux	Family and Children	45+ Years, Male	1,015	$ 428.45
03	Thibodaux	Foster Care Children	Foster Care, All Ages Male & Female	6,367	$ 134.63
03	Thibodaux	Breast and Cervical Cancer	BCC, All Ages Female	1,073	$ 1,893.60
03	Thibodaux	Maternity Kickpayment	Maternity Kickpayment, All Ages	3,633	$ 4,831.38

Attachment A

CCN-S Benchmark PMPM Summary

				3/1/2012-12/31/2012	
					CCN-S Benchmark PMPM
DHH Administrative Region	Region Description	COA Description	RC Description	FY10 Member Months or Deliveries	PMPM or Cost/Delivery
04	LaFayette	SSI	0-2 Months, Male and Female	241	$ 16,720.82
04	LaFayette	SSI	3-11 Months, Male and Female	1,009	$ 3,618.81
04	LaFayette	SSI	1-5 Years, Male and Female	10,033	$ 641.60
04	LaFayette	SSI	6-13 Years, Male and Female	20,942	$ 203.12
04	LaFayette	SSI	14-18 Years, Male and Female	13,191	$ 215.89
04	LaFayette	SSI	19-44 Years, Male and Female	50,949	$ 462.19
04	LaFayette	SSI	45+ Years, Male and Female	75,776	$ 734.18
04	LaFayette	Family and Children	0-2 Months, Male and Female	25,893	$ 1,315.93
04	LaFayette	Family and Children	3-11 Months, Male and Female	58,513	$ 240.42
04	LaFayette	Family and Children	1-5 Years, Male and Female	326,436	$ 100.32
04	LaFayette	Family and Children	6-13 Years, Male and Female	420,910	$ 66.20
04	LaFayette	Family and Children	14-18 Years, Female	118,613	$ 101.38
04	LaFayette	Family and Children	14-18 Years, Male	110,594	$ 69.97
04	LaFayette	Family and Children	19-44 Years, Female	137,629	$ 206.29
04	LaFayette	Family and Children	19-44 Years, Male	7,959	$ 222.78
04	LaFayette	Family and Children	45+ Years, Female	5,373	$ 367.09
04	LaFayette	Family and Children	45+ Years, Male	1,712	$ 428.45
04	LaFayette	Foster Care Children	Foster Care, All Ages Male & Female	17,383	$ 134.63
04	LaFayette	Breast and Cervical Cancer	BCC, All Ages Female	1,428	$ 1,893.60
04	LaFayette	Maternity Kickpayment	Maternity Kickpayment, All Ages	5,865	$ 4,244.15

Attachment A

CCN-S Benchmark PMPM Summary

				5/1/2012-12/31/2012	
					CCN-S Benchmark PMPM
DHH Administrative Region	Region Description	COA Description	RC Description	FY10 Member Months or Deliveries	PMPM or Cost/Delivery
05	Lake Charles	SSI	0-2 Months, Male and Female	103	$ 16,747.48
05	Lake Charles	SSI	3-11 Months, Male and Female	498	$ 3,625.88
05	Lake Charles	SSI	1-5 Years, Male and Female	4,324	$ 643.39
05	Lake Charles	SSI	6-13 Years, Male and Female	10,075	$ 203.74
05	Lake Charles	SSI	14-18 Years, Male and Female	5,898	$ 216.57
05	Lake Charles	SSI	19-44 Years, Male and Female	20,136	$ 417.03
05	Lake Charles	SSI	45+ Years, Male and Female	28,765	$ 734.16
05	Lake Charles	Family and Children	0-2 Months, Male and Female	12,072	$ 1,308.65
05	Lake Charles	Family and Children	3-11 Months, Male and Female	27,288	$ 259.17
05	Lake Charles	Family and Children	1-5 Years, Male and Female	154,451	$ 114.05
05	Lake Charles	Family and Children	6-13 Years, Male and Female	197,659	$ 73.36
05	Lake Charles	Family and Children	14-18 Years, Female	53,654	$ 114.29
05	Lake Charles	Family and Children	14-18 Years, Male	51,009	$ 76.52
05	Lake Charles	Family and Children	19-44 Years, Female	52,599	$ 237.87
05	Lake Charles	Family and Children	19-44 Years, Male	2,684	$ 223.56
05	Lake Charles	Family and Children	45+ Years, Female	1,715	$ 368.30
05	Lake Charles	Family and Children	45+ Years, Male	473	$ 429.77
05	Lake Charles	Foster Care Children	Foster Care, All Ages Male & Female	10,081	$ 135.09
05	Lake Charles	Breast and Cervical Cancer	BCC, All Ages Female	780	$ 1,902.05
05	Lake Charles	Maternity Kickpayment	Maternity Kickpayment, All Ages	2,699	$ 4,394.07
06	Alexandria	SSI	0-2 Months, Male and Female	151	$ 16,747.48
06	Alexandria	SSI	3-11 Months, Male and Female	535	$ 3,625.88
06	Alexandria	SSI	1-5 Years, Male and Female	6,265	$ 643.39
06	Alexandria	SSI	6-13 Years, Male and Female	15,447	$ 203.74
06	Alexandria	SSI	14-18 Years, Male and Female	9,554	$ 216.57
06	Alexandria	SSI	19-44 Years, Male and Female	33,689	$ 381.39
06	Alexandria	SSI	45+ Years, Male and Female	41,654	$ 727.62
06	Alexandria	Family and Children	0-2 Months, Male and Female	12,559	$ 1,468.14
06	Alexandria	Family and Children	3-11 Months, Male and Female	29,209	$ 242.71
06	Alexandria	Family and Children	1-5 Years, Male and Female	168,417	$ 115.51
06	Alexandria	Family and Children	6-13 Years, Male and Female	223,939	$ 74.12
06	Alexandria	Family and Children	14-18 Years, Female	63,993	$ 116.26
06	Alexandria	Family and Children	14-18 Years, Male	59,733	$ 78.74
06	Alexandria	Family and Children	19-44 Years, Female	62,895	$ 226.21
06	Alexandria	Family and Children	19-44 Years, Male	3,791	$ 223.56
06	Alexandria	Family and Children	45+ Years, Female	2,107	$ 368.30
06	Alexandria	Family and Children	45+ Years, Male	651	$ 429.77
06	Alexandria	Foster Care Children	Foster Care, All Ages Male & Female	10,979	$ 135.09
06	Alexandria	Breast and Cervical Cancer	BCC, All Ages Female	686	$ 1,902.05
06	Alexandria	Maternity Kickpayment	Maternity Kickpayment, All Ages	2,817	$ 4,500.92

Attachment A

CCN-S Benchmark PMPM Summary

				5/1/2012-12/31/2012	
					CCN-S Benchmark PMPM
DHH Administrative Region	Region Description	COA Description	RC Description	FY10 Member Months or Deliveries	PMPM or Cost/Delivery
07	Shreveport	SSI	0-2 Months, Male and Female	273	$ 16,747.48
07	Shreveport	SSI	3-11 Months, Male and Female	1,167	$ 3,625.88
07	Shreveport	SSI	1-5 Years, Male and Female	13,246	$ 643.39
07	Shreveport	SSI	6-13 Years, Male and Female	30,446	$ 203.74
07	Shreveport	SSI	14-18 Years, Male and Female	20,251	$ 216.57
07	Shreveport	SSI	19-44 Years, Male and Female	55,236	$ 480.03
07	Shreveport	SSI	45+ Years, Male and Female	64,022	$ 736.34
07	Shreveport	Family and Children	0-2 Months, Male and Female	21,441	$ 1,453.98
07	Shreveport	Family and Children	3-11 Months, Male and Female	48,977	$ 234.85
07	Shreveport	Family and Children	1-5 Years, Male and Female	287,394	$ 100.22
07	Shreveport	Family and Children	6-13 Years, Male and Female	364,405	$ 59.62
07	Shreveport	Family and Children	14-18 Years, Female	102,998	$ 108.62
07	Shreveport	Family and Children	14-18 Years, Male	92,118	$ 64.58
07	Shreveport	Family and Children	19-44 Years, Female	113,294	$ 227.03
07	Shreveport	Family and Children	19-44 Years, Male	3,647	$ 223.56
07	Shreveport	Family and Children	45+ Years, Female	4,287	$ 368.30
07	Shreveport	Family and Children	45+ Years, Male	803	$ 429.77
07	Shreveport	Foster Care Children	Foster Care, All Ages Male & Female	12,260	$ 135.09
07	Shreveport	Breast and Cervical Cancer	BCC, All Ages Female	1,161	$ 1,902.05
07	Shreveport	Maternity Kickpayment	Maternity Kickpayment, All Ages	4,743	$ 4,833.32
08	Monroe	SSI	0-2 Months, Male and Female	123	$ 16,747.48
08	Monroe	SSI	3-11 Months, Male and Female	621	$ 3,625.88
08	Monroe	SSI	1-5 Years, Male and Female	7,356	$ 643.39
08	Monroe	SSI	6-13 Years, Male and Female	18,521	$ 203.74
08	Monroe	SSI	14-18 Years, Male and Female	12,113	$ 216.57
08	Monroe	SSI	19-44 Years, Male and Female	35,899	$ 433.20
08	Monroe	SSI	45+ Years, Male and Female	43,661	$ 756.86
08	Monroe	Family and Children	0-2 Months, Male and Female	16,160	$ 1,511.22
08	Monroe	Family and Children	3-11 Months, Male and Female	37,261	$ 293.69
08	Monroe	Family and Children	1-5 Years, Male and Female	215,906	$ 126.93
08	Monroe	Family and Children	6-13 Years, Male and Female	284,305	$ 71.73
08	Monroe	Family and Children	14-18 Years, Female	81,887	$ 114.65
08	Monroe	Family and Children	14-18 Years, Male	77,549	$ 77.00
08	Monroe	Family and Children	19-44 Years, Female	97,644	$ 207.94
08	Monroe	Family and Children	19-44 Years, Male	4,323	$ 223.56
08	Monroe	Family and Children	45+ Years, Female	3,589	$ 368.30
08	Monroe	Family and Children	45+ Years, Male	784	$ 429.77
08	Monroe	Foster Care Children	Foster Care, All Ages Male & Female	9,459	$ 135.09
08	Monroe	Breast and Cervical Cancer	BCC, All Ages Female	1,197	$ 1,902.05
08	Monroe	Maternity Kickpayment	Maternity Kickpayment, All Ages	3,756	$ 4,989.16

Attachment B

CCN-S Benchmark PMPM Development

				1/1/2012-12/31/2012									1/1/2012-12/31/2012						
				State Fiscal Year 2009 Rate Development									State Fiscal Year 2010 Rate Development						
				FY09 CCN-S Base PMPM	Adjustments					FY09 CCN-S PMPM Post Adjustments		Projected FY10 CCN-S PMPM	FY10 CCN-S Base PMPM	Adjustments					FY10 CCN-S PMPM Post Adjustments
DHH Administrative Region	Region Description	COA Description	RC Description	PMPM or Cost/Delivery	Completion Factor	Program Integrity Recoupments (Fraud & Abuse)	Rx Rebate	IP and OP Hospital Cost Settlements	Fee Schedule Changes	PMPM or Cost/Delivery	Trend to FY10	PMPM or Cost/Delivery	PMPM or Cost/Delivery	Completion Factor	Program Integrity Recoupments (Fraud & Abuse)	Rx Rebate	IP and OP Hospital Cost Settlements	Fee Schedule Changes	PMPM or Cost/Delivery
01	New Orleans	SSI	0-2 Months, Male and Female	$ 15,323.17	1.0018	0.9969	0.9935	1.1281	0.9411	$ 16,141.66	2.0%	$ 16,469.62	$ 18,342.63	1.0636	0.9990	0.9951	1.0382	0.9586	$ 19,302.21
01	New Orleans	SSI	3-11 Months, Male and Female	$ 3,446.20	1.0011	0.9976	0.9328	1.1033	0.9463	$ 3,352.11	2.2%	$ 3,427.24	$ 4,035.95	1.0536	0.9995	0.9532	1.0260	0.9615	$ 3,996.60
01	New Orleans	SSI	1-5 Years, Male and Female	$ 705.49	1.0003	0.9981	0.9056	1.0638	0.9496	$ 644.41	2.9%	$ 663.30	$ 782.84	1.0443	0.9995	0.9315	1.0091	0.9653	$ 741.46
01	New Orleans	SSI	6-13 Years, Male and Female	$ 195.61	0.9996	0.9986	0.8673	1.0206	0.9487	$ 163.98	3.6%	$ 169.91	$ 212.03	1.0273	0.9994	0.8623	0.9918	0.9703	$ 180.63
01	New Orleans	SSI	14-18 Years, Male and Female	$ 184.83	0.9996	0.9986	0.8709	1.0279	0.9433	$ 155.80	3.7%	$ 161.52	$ 240.27	1.0326	0.9994	0.8874	0.9961	0.9646	$ 211.41
01	New Orleans	SSI	19-44 Years, Male and Female	$ 535.21	1.0002	0.9982	0.9097	1.0545	0.9373	$ 480.42	3.3%	$ 496.47	$ 566.38	1.0365	0.9994	0.9033	1.0012	0.9604	$ 509.60
01	New Orleans	SSI	45+ Years, Male and Female	$ 942.21	1.0000	0.9981	0.8968	1.0407	0.9385	$ 823.74	3.4%	$ 851.96	$ 915.82	1.0341	0.9993	0.8925	0.9921	0.9621	$ 806.27
01	New Orleans	Family and Children	0-2 Months, Male and Female	$ 1,283.96	1.0019	0.9972	0.9905	1.1134	0.9118	$ 1,289.96	2.1%	$ 1,316.67	$ 1,277.83	1.0503	0.9991	0.9922	1.0341	0.9265	$ 1,274.58
01	New Orleans	Family and Children	3-11 Months, Male and Female	$ 218.92	0.9976	0.9985	0.9027	1.0383	0.9398	$ 192.09	3.3%	$ 198.34	$ 202.39	1.0202	0.9990	0.9120	1.0011	0.9551	$ 179.85
01	New Orleans	Family and Children	1-5 Years, Male and Female	$ 97.07	0.9964	0.9987	0.8789	1.0115	0.9400	$ 80.73	3.8%	$ 83.78	$ 99.22	1.0123	0.9988	0.8814	0.9896	0.9565	$ 83.69
01	New Orleans	Family and Children	6-13 Years, Male and Female	$ 61.84	0.9963	0.9987	0.8794	1.0065	0.9399	$ 51.19	3.8%	$ 53.15	$ 65.06	1.0098	0.9987	0.8688	0.9873	0.9594	$ 53.99
01	New Orleans	Family and Children	14-18 Years, Female	$ 94.01	0.9963	0.9988	0.9016	1.0082	0.9274	$ 78.85	4.1%	$ 82.09	$ 97.05	1.0137	0.9989	0.9002	0.9859	0.9502	$ 82.87
01	New Orleans	Family and Children	14-18 Years, Male	$ 64.00	0.9966	0.9986	0.9083	1.0086	0.9298	$ 54.25	4.1%	$ 56.46	$ 72.74	1.0193	0.9989	0.9145	0.9899	0.9482	$ 63.57
01	New Orleans	Family and Children	19-44 Years, Female	$ 197.91	0.9973	0.9985	0.9205	1.0210	0.9156	$ 169.58	4.0%	$ 176.33	$ 207.26	1.0192	0.9990	0.9218	0.9851	0.9418	$ 180.48
01	New Orleans	Family and Children	19-44 Years, Male	$ 224.90	0.9980	0.9983	0.9069	1.0391	0.9193	$ 194.13	3.6%	$ 201.06	$ 198.50	1.0200	0.9989	0.9097	0.9963	0.9450	$ 173.24
01	New Orleans	Family and Children	45+ Years, Female	$ 335.14	0.9965	0.9985	0.8700	0.9974	0.9266	$ 268.12	4.0%	$ 278.80	$ 352.45	1.0170	0.9990	0.8786	0.9874	0.9463	$ 293.93
01	New Orleans	Family and Children	45+ Years, Male	$ 422.98	0.9971	0.9986	0.8450	1.0238	0.9322	$ 339.67	3.3%	$ 350.94	$ 442.31	1.0156	0.9990	0.8675	0.9778	0.9479	$ 360.83
01	New Orleans	Foster Care Children	Foster Care, All Ages Male & Female	$ 196.43	1.0003	0.9981	0.9222	1.0561	0.9259	$ 176.87	3.2%	$ 182.61	$ 140.83	1.0333	0.9990	0.9145	0.9928	0.9574	$ 126.37
01	New Orleans	Breast and Cervical Cancer	BCC, All Ages Female	$ 2,299.34	0.9987	0.9975	0.9453	0.9073	0.9152	$ 1,798.01	7.4%	$ 1,930.75	$ 1,970.38	1.0218	0.9996	0.9338	0.8578	0.9719	$ 1,566.91
01	New Orleans	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 6,850.44	1.0000	1.0000	1.0000	1.0000	0.9157	$ 6,272.83	0.0%	$ 6,272.83	$ 6,944.17	1.0000	1.0000	1.0000	1.0000	0.9376	$ 6,510.59
09	Mandeville	SSI	0-2 Months, Male and Female	$ 13,568.66	1.0017	0.9969	0.9929	1.0134	0.9417	$ 12,839.85	2.1%	$ 13,115.49	$ 20,588.02	1.0655	0.9993	0.9957	1.0143	0.9575	$ 21,199.20
09	Mandeville	SSI	3-11 Months, Male and Female	$ 3,628.76	1.0003	0.9982	0.8685	1.0063	0.9547	$ 3,023.17	2.5%	$ 3,098.96	$ 4,887.89	1.0545	0.9991	0.9676	1.0084	0.9620	$ 4,833.94
09	Mandeville	SSI	1-5 Years, Male and Female	$ 1,047.86	1.0003	0.9983	0.9133	1.0034	0.9540	$ 914.72	3.2%	$ 943.86	$ 690.83	1.0334	0.9993	0.8999	0.9961	0.9727	$ 622.02
09	Mandeville	SSI	6-13 Years, Male and Female	$ 237.43	0.9995	0.9989	0.8748	0.9975	0.9551	$ 197.56	3.8%	$ 205.12	$ 257.36	1.0249	0.9992	0.8735	0.9915	0.9759	$ 222.75
09	Mandeville	SSI	14-18 Years, Male and Female	$ 223.42	0.9996	0.9988	0.8891	0.9981	0.9423	$ 186.54	4.0%	$ 194.09	$ 219.07	1.0264	0.9992	0.8934	0.9911	0.9689	$ 192.74
09	Mandeville	SSI	19-44 Years, Male and Female	$ 533.06	0.9996	0.9986	0.8703	0.9975	0.9384	$ 433.48	3.9%	$ 450.57	$ 576.31	1.0286	0.9994	0.8717	0.9951	0.9627	$ 494.70
09	Mandeville	SSI	45+ Years, Male and Female	$ 938.36	0.9997	0.9984	0.8723	0.9968	0.9398	$ 765.27	3.8%	$ 794.10	$ 958.77	1.0294	0.9992	0.8703	0.9941	0.9641	$ 822.49
09	Mandeville	Family and Children	0-2 Months, Male and Female	$ 1,381.66	1.0016	0.9972	0.9841	1.0116	0.9145	$ 1,256.36	2.2%	$ 1,283.74	$ 1,160.33	1.0477	0.9989	0.9891	1.0109	0.9286	$ 1,127.48
09	Mandeville	Family and Children	3-11 Months, Male and Female	$ 281.08	0.9970	0.9987	0.8715	1.0010	0.9464	$ 231.05	3.3%	$ 238.73	$ 243.80	1.0137	0.9987	0.8776	0.9983	0.9600	$ 207.60
09	Mandeville	Family and Children	1-5 Years, Male and Female	$ 122.25	0.9961	0.9988	0.8683	0.9967	0.9431	$ 99.27	3.9%	$ 103.12	$ 124.50	1.0098	0.9985	0.8674	0.9947	0.9592	$ 103.88
09	Mandeville	Family and Children	6-13 Years, Male and Female	$ 82.31	0.9958	0.9989	0.8668	0.9965	0.9448	$ 66.82	3.9%	$ 69.45	$ 87.82	1.0086	0.9987	0.8658	0.9943	0.9628	$ 73.32
09	Mandeville	Family and Children	14-18 Years, Female	$ 125.61	0.9958	0.9990	0.8982	0.9943	0.9309	$ 103.88	4.4%	$ 108.49	$ 123.91	1.0091	0.9989	0.8836	0.9920	0.9570	$ 104.78
09	Mandeville	Family and Children	14-18 Years, Male	$ 89.34	0.9962	0.9988	0.8989	0.9959	0.9334	$ 74.28	4.2%	$ 77.41	$ 90.45	1.0091	0.9988	0.8784	0.9918	0.9589	$ 76.16
09	Mandeville	Family and Children	19-44 Years, Female	$ 261.40	0.9966	0.9987	0.9076	0.9952	0.9196	$ 216.10	4.3%	$ 225.45	$ 254.23	1.0152	0.9991	0.9030	0.9912	0.9454	$ 218.20
09	Mandeville	Family and Children	19-44 Years, Male	$ 269.80	0.9966	0.9988	0.8652	0.9977	0.9287	$ 215.29	4.0%	$ 223.88	$ 302.53	1.0164	0.9991	0.8851	0.9943	0.9466	$ 255.92
09	Mandeville	Family and Children	45+ Years, Female	$ 496.61	0.9961	0.9988	0.8499	0.9925	0.9333	$ 388.96	4.0%	$ 404.61	$ 509.10	1.0140	0.9990	0.8602	0.9946	0.9493	$ 418.83
09	Mandeville	Family and Children	45+ Years, Male	$ 929.28	0.9981	0.9983	0.8796	0.9997	0.9266	$ 754.33	3.2%	$ 778.72	$ 495.29	1.0106	0.9989	0.8335	0.9968	0.9544	$ 396.45
09	Mandeville	Foster Care Children	Foster Care, All Ages Male & Female	$ 168.88	0.9994	0.9989	0.8596	0.9979	0.9435	$ 136.44	3.7%	$ 141.54	$ 141.25	1.0228	0.9987	0.8677	0.9931	0.9639	$ 119.85
09	Mandeville	Breast and Cervical Cancer	BCC, All Ages Female	$ 1,222.51	0.9989	0.9981	0.9362	0.9713	0.9057	$ 1,003.88	6.6%	$ 1,070.55	$ 1,066.23	1.0256	0.9995	0.9280	0.9576	0.9618	$ 934.11
09	Mandeville	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 5,143.09	1.0000	1.0000	1.0000	1.0000	0.9157	$ 4,709.44	0.0%	$ 4,709.44	$ 4,942.22	1.0000	1.0000	1.0000	1.0000	0.9376	$ 4,633.64

Attachment B

CCN-S Benchmark PMPM Development

				1/1/2012-12/31/2012					
				Weighted FY09 and FY10 PMPM at FY10		Projected FFS PMPM	PMPM Post Smoothing w/Statewide		CCN-S Benchmark PMPM
DHH Administrative Region	Region Description	COA Description	RC Description	PMPM or Cost/Delivery	Trend	PMPM or Cost/Delivery	PMPM or Cost/Delivery	Catastrophic Limit Adjustment	PMPM or Cost/Delivery
01	New Orleans	SSI	0-2 Months, Male and Female	$ 18,169.17	2.10%	$ 19,137.75	$ 18,106.40	0.9220	$ 16,694.19
01	New Orleans	SSI	3-11 Months, Male and Female	$ 3,768.86	2.40%	$ 3,999.46	$ 3,917.31	0.9220	$ 3,611.77
01	New Orleans	SSI	1-5 Years, Male and Female	$ 710.20	3.09%	$ 766.34	$ 693.95	0.9220	$ 639.82
01	New Orleans	SSI	6-13 Years, Male and Female	$ 176.34	3.70%	$ 193.12	$ 219.65	0.9220	$ 202.51
01	New Orleans	SSI	14-18 Years, Male and Female	$ 191.46	3.73%	$ 209.81	$ 233.43	0.9220	$ 215.22
01	New Orleans	SSI	19-44 Years, Male and Female	$ 504.35	3.51%	$ 549.83	$ 549.83	0.9220	$ 506.94
01	New Orleans	SSI	45+ Years, Male and Female	$ 824.54	3.58%	$ 900.25	$ 900.25	0.9220	$ 830.02
01	New Orleans	Family and Children	0-2 Months, Male and Female	$ 1,291.42	2.10%	$ 1,360.13	$ 1,360.13	0.9551	$ 1,299.04
01	New Orleans	Family and Children	3-11 Months, Male and Female	$ 187.25	3.44%	$ 203.76	$ 203.76	0.9551	$ 194.61
01	New Orleans	Family and Children	1-5 Years, Male and Female	$ 83.73	3.92%	$ 92.18	$ 92.18	0.9551	$ 88.04
01	New Orleans	Family and Children	6-13 Years, Male and Female	$ 53.65	3.95%	$ 59.10	$ 59.10	0.9551	$ 56.45
01	New Orleans	Family and Children	14-18 Years, Female	$ 82.56	4.25%	$ 91.62	$ 91.62	0.9551	$ 87.50
01	New Orleans	Family and Children	14-18 Years, Male	$ 60.72	4.00%	$ 66.98	$ 66.98	0.9551	$ 63.97
01	New Orleans	Family and Children	19-44 Years, Female	$ 178.82	4.17%	$ 198.03	$ 198.03	0.9551	$ 189.13
01	New Orleans	Family and Children	19-44 Years, Male	$ 184.37	3.75%	$ 202.13	$ 232.46	0.9551	$ 222.02
01	New Orleans	Family and Children	45+ Years, Female	$ 287.88	3.80%	$ 316.05	$ 383.09	0.9551	$ 365.89
01	New Orleans	Family and Children	45+ Years, Male	$ 356.87	3.55%	$ 389.35	$ 447.23	0.9551	$ 427.14
01	New Orleans	Foster Care Children	Foster Care, All Ages Male & Female	$ 148.86	3.71%	$ 163.04	$ 142.91	0.9389	$ 134.18
01	New Orleans	Breast and Cervical Cancer	BCC, All Ages Female	$ 1,712.45	7.57%	$ 2,054.99	$ 2,068.39	0.9114	$ 1,885.19
01	New Orleans	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 6,415.49	0.00%	$ 6,415.49	$ 6,415.49	1.0000	$ 6,415.49
09	Mandeville	SSI	0-2 Months, Male and Female	$ 17,965.72	2.06%	$ 18,905.32	$ 18,106.40	0.9220	$ 16,694.19
09	Mandeville	SSI	3-11 Months, Male and Female	$ 4,139.95	2.60%	$ 4,413.99	$ 3,917.31	0.9220	$ 3,611.77
09	Mandeville	SSI	1-5 Years, Male and Female	$ 750.76	3.56%	$ 819.41	$ 693.95	0.9220	$ 639.82
09	Mandeville	SSI	6-13 Years, Male and Female	$ 215.70	4.15%	$ 238.76	$ 219.65	0.9220	$ 202.51
09	Mandeville	SSI	14-18 Years, Male and Female	$ 193.28	4.43%	$ 215.43	$ 233.43	0.9220	$ 215.22
09	Mandeville	SSI	19-44 Years, Male and Female	$ 477.05	4.03%	$ 526.58	$ 526.58	0.9220	$ 485.50
09	Mandeville	SSI	45+ Years, Male and Female	$ 811.13	3.85%	$ 891.45	$ 891.45	0.9220	$ 821.90
09	Mandeville	Family and Children	0-2 Months, Male and Female	$ 1,189.98	2.22%	$ 1,257.01	$ 1,257.01	0.9551	$ 1,200.55
09	Mandeville	Family and Children	3-11 Months, Male and Female	$ 220.05	3.48%	$ 239.69	$ 239.69	0.9551	$ 228.93
09	Mandeville	Family and Children	1-5 Years, Male and Female	$ 103.58	3.94%	$ 114.09	$ 114.09	0.9551	$ 108.97
09	Mandeville	Family and Children	6-13 Years, Male and Female	$ 71.77	3.99%	$ 79.14	$ 79.14	0.9551	$ 75.59
09	Mandeville	Family and Children	14-18 Years, Female	$ 106.27	4.50%	$ 118.61	$ 118.61	0.9551	$ 113.29
09	Mandeville	Family and Children	14-18 Years, Male	$ 76.66	4.35%	$ 85.28	$ 85.28	0.9551	$ 81.45
09	Mandeville	Family and Children	19-44 Years, Female	$ 221.10	4.46%	$ 246.57	$ 246.57	0.9551	$ 235.50
09	Mandeville	Family and Children	19-44 Years, Male	$ 243.11	4.06%	$ 268.56	$ 232.46	0.9551	$ 222.02
09	Mandeville	Family and Children	45+ Years, Female	$ 413.14	3.87%	$ 454.25	$ 383.09	0.9551	$ 365.89
09	Mandeville	Family and Children	45+ Years, Male	$ 549.36	3.41%	$ 597.40	$ 447.23	0.9551	$ 427.14
09	Mandeville	Foster Care Children	Foster Care, All Ages Male & Female	$ 128.53	4.05%	$ 141.95	$ 142.91	0.9389	$ 134.18
09	Mandeville	Breast and Cervical Cancer	BCC, All Ages Female	$ 988.69	6.78%	$ 1,164.97	$ 2,068.39	0.9114	$ 1,885.19
09	Mandeville	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 4,663.96	0.00%	$ 4,663.96	$ 4,663.96	1.0000	$ 4,663.96

Attachment B

CCN-S Benchmark PMPM Development

				3/1/2011-12/31/2012									3/1/2011-12/31/2012						
				State Fiscal Year 2009 Rate Development									State Fiscal Year 2010 Rate Development						
				FY09 CCN-S Base PMPM	Adjustments					FY09 CCN-S PMPM Post Adjustments		Projected FY10 CCN-S PMPM	FY10 CCN-S Base PMPM	Adjustments					FY10 CCN-S PMPM Post Adjustments
DHH Administrative Region	Region Description	COA Description	RC Description	PMPM or Cost/Delivery	Completion Factor	Program Integrity Recoupments (Fraud & Abuse)	Rx Rebate	IP and OP Hospital Cost Settlements	Fee Schedule Changes	PMPM or Cost/Delivery	Trend to FY10	PMPM or Cost/Delivery	PMPM or Cost/Delivery	Completion Factor	Program Integrity Recoupments (Fraud & Abuse)	Rx Rebate	IP and OP Hospital Cost Settlements	Fee Schedule Changes	PMPM or Cost/Delivery
02	Baton Rouge	SSI	0-2 Months, Male and Female	$ 16,493.33	1.0017	0.9969	0.9971	1.0629	0.9415	$ 16,433.55	2.2%	$ 16,792.96	$ 19,682.85	1.0649	0.9991	0.9973	1.0399	0.9579	$ 20,803.96
02	Baton Rouge	SSI	3-11 Months, Male and Female	$ 4,728.01	1.0009	0.9976	0.9352	1.0516	0.9488	$ 4,405.47	2.4%	$ 4,513.25	$ 3,807.82	1.0502	0.9993	0.9388	1.0299	0.9639	$ 3,724.76
02	Baton Rouge	SSI	1-5 Years, Male and Female	$ 653.32	0.9998	0.9986	0.8748	1.0284	0.9571	$ 561.71	3.4%	$ 580.68	$ 640.42	1.0376	0.9992	0.9133	1.0139	0.9714	$ 597.29
02	Baton Rouge	SSI	6-13 Years, Male and Female	$ 180.08	0.9995	0.9988	0.8672	1.0217	0.9520	$ 151.64	3.7%	$ 157.22	$ 251.17	1.0309	0.9993	0.8704	1.0131	0.9708	$ 221.48
02	Baton Rouge	SSI	14-18 Years, Male and Female	$ 217.37	0.9995	0.9988	0.8614	1.0233	0.9479	$ 181.31	3.7%	$ 188.06	$ 230.61	1.0273	0.9993	0.8617	1.0094	0.9695	$ 199.62
02	Baton Rouge	SSI	19-44 Years, Male and Female	$ 593.48	0.9999	0.9984	0.8822	1.0360	0.9398	$ 508.95	3.5%	$ 526.55	$ 622.86	1.0323	0.9995	0.8742	1.0153	0.9622	$ 548.81
02	Baton Rouge	SSI	45+ Years, Male and Female	$ 945.77	0.9997	0.9985	0.8695	1.0322	0.9389	$ 795.47	3.8%	$ 825.53	$ 859.66	1.0273	0.9993	0.8634	1.0060	0.9636	$ 738.74
02	Baton Rouge	Family and Children	0-2 Months, Male and Female	$ 1,471.78	1.0023	0.9971	0.9928	1.0631	0.9119	$ 1,415.51	2.0%	$ 1,443.85	$ 1,255.90	1.0507	0.9990	0.9923	1.0358	0.9267	$ 1,255.46
02	Baton Rouge	Family and Children	3-11 Months, Male and Female	$ 239.20	0.9977	0.9985	0.8974	1.0276	0.9409	$ 206.75	3.2%	$ 213.40	$ 225.31	1.0201	0.9989	0.8996	1.0117	0.9547	$ 199.46
02	Baton Rouge	Family and Children	1-5 Years, Male and Female	$ 94.27	0.9963	0.9987	0.8773	1.0159	0.9430	$ 78.84	3.8%	$ 81.84	$ 96.57	1.0105	0.9986	0.8691	1.0024	0.9598	$ 81.49
02	Baton Rouge	Family and Children	6-13 Years, Male and Female	$ 60.44	0.9959	0.9989	0.8631	1.0118	0.9468	$ 49.72	3.8%	$ 51.61	$ 64.75	1.0080	0.9987	0.8576	1.0010	0.9642	$ 53.95
02	Baton Rouge	Family and Children	14-18 Years, Female	$ 93.19	0.9961	0.9989	0.9003	1.0148	0.9327	$ 79.02	4.2%	$ 82.37	$ 95.29	1.0121	0.9990	0.8971	1.0004	0.9555	$ 82.61
02	Baton Rouge	Family and Children	14-18 Years, Male	$ 62.46	0.9962	0.9988	0.9019	1.0159	0.9333	$ 53.14	4.2%	$ 55.38	$ 68.02	1.0139	0.9988	0.9028	1.0019	0.9551	$ 59.51
02	Baton Rouge	Family and Children	19-44 Years, Female	$ 213.74	0.9968	0.9987	0.9037	1.0236	0.9191	$ 180.91	4.3%	$ 188.63	$ 212.13	1.0155	0.9993	0.8962	1.0021	0.9453	$ 182.75
02	Baton Rouge	Family and Children	19-44 Years, Male	$ 270.84	0.9972	0.9986	0.8964	1.0270	0.9226	$ 229.09	4.0%	$ 238.19	$ 263.40	1.0158	0.9992	0.8740	1.0070	0.9475	$ 222.93
02	Baton Rouge	Family and Children	45+ Years, Female	$ 390.39	0.9967	0.9986	0.8631	1.0246	0.9296	$ 319.39	3.9%	$ 331.98	$ 393.84	1.0121	0.9991	0.8630	0.9997	0.9516	$ 326.92
02	Baton Rouge	Family and Children	45+ Years, Male	$ 444.84	0.9967	0.9985	0.8853	1.0248	0.9232	$ 370.82	4.2%	$ 386.29	$ 376.73	1.0115	0.9992	0.8288	1.0084	0.9530	$ 303.27
02	Baton Rouge	Foster Care Children	Foster Care, All Ages Male & Female	$ 113.45	0.9993	0.9990	0.8876	1.0122	0.9418	$ 95.83	4.3%	$ 99.95	$ 129.44	1.0290	0.9989	0.9011	1.0046	0.9640	$ 116.10
02	Baton Rouge	Breast and Cervical Cancer	BCC, All Ages Female	$ 2,180.31	0.9988	0.9976	0.9555	1.0423	0.9060	$ 1,960.36	7.8%	$ 2,113.55	$ 1,708.36	1.0237	0.9997	0.9280	0.9718	0.9631	$ 1,518.41
02	Baton Rouge	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 5,340.23	1.0000	1.0000	1.0000	1.0000	0.9157	$ 4,889.95	0.0%	$ 4,889.95	$ 5,193.75	1.0000	1.0000	1.0000	1.0000	0.9376	$ 4,869.47
03	Thibodaux	SSI	0-2 Months, Male and Female	$ 7,012.30	1.0017	0.9970	0.9895	1.0898	0.9409	$ 7,105.11	2.1%	$ 7,256.10	$ 21,452.16	1.0657	0.9992	0.9979	1.1048	0.9571	$ 24,102.02
03	Thibodaux	SSI	3-11 Months, Male and Female	$ 3,690.23	1.0008	0.9978	0.9225	1.0721	0.9496	$ 3,461.26	2.4%	$ 3,545.40	$ 3,127.97	1.0505	0.9993	0.9434	1.0796	0.9635	$ 3,222.51
03	Thibodaux	SSI	1-5 Years, Male and Female	$ 452.20	0.9998	0.9986	0.8735	1.0471	0.9515	$ 392.88	3.5%	$ 406.73	$ 568.50	1.0271	0.9995	0.8593	1.0321	0.9748	$ 504.57
03	Thibodaux	SSI	6-13 Years, Male and Female	$ 165.02	0.9994	0.9988	0.8711	1.0335	0.9483	$ 140.64	4.1%	$ 146.47	$ 182.47	1.0260	0.9992	0.8765	1.0244	0.9718	$ 163.24
03	Thibodaux	SSI	14-18 Years, Male and Female	$ 200.54	0.9995	0.9988	0.8814	1.0395	0.9417	$ 172.73	4.1%	$ 179.88	$ 195.84	1.0230	0.9993	0.8692	1.0186	0.9685	$ 171.65
03	Thibodaux	SSI	19-44 Years, Male and Female	$ 438.98	0.9995	0.9986	0.8769	1.0481	0.9363	$ 377.07	4.3%	$ 393.32	$ 467.66	1.0269	0.9995	0.8753	1.0346	0.9624	$ 418.30
03	Thibodaux	SSI	45+ Years, Male and Female	$ 842.17	0.9996	0.9984	0.8793	1.0575	0.9355	$ 731.07	4.4%	$ 762.94	$ 816.59	1.0269	0.9993	0.8732	1.0348	0.9640	$ 729.92
03	Thibodaux	Family and Children	0-2 Months, Male and Female	$ 1,120.82	1.0014	0.9973	0.9874	1.0789	0.9141	$ 1,089.97	2.2%	$ 1,114.13	$ 1,073.69	1.0468	0.9989	0.9877	1.0843	0.9287	$ 1,116.76
03	Thibodaux	Family and Children	3-11 Months, Male and Female	$ 243.44	0.9972	0.9986	0.8932	1.0344	0.9445	$ 211.52	3.4%	$ 218.67	$ 222.51	1.0136	0.9988	0.8856	1.0222	0.9615	$ 196.08
03	Thibodaux	Family and Children	1-5 Years, Male and Female	$ 109.97	0.9960	0.9989	0.8740	1.0223	0.9450	$ 92.38	4.0%	$ 96.05	$ 116.09	1.0100	0.9987	0.8719	1.0154	0.9602	$ 99.55
03	Thibodaux	Family and Children	6-13 Years, Male and Female	$ 71.22	0.9957	0.9990	0.8768	1.0197	0.9452	$ 59.86	4.1%	$ 62.32	$ 78.86	1.0079	0.9987	0.8693	1.0096	0.9642	$ 67.17
03	Thibodaux	Family and Children	14-18 Years, Female	$ 123.17	0.9958	0.9989	0.9084	1.0255	0.9313	$ 106.30	4.5%	$ 111.04	$ 126.44	1.0108	0.9989	0.9001	1.0103	0.9557	$ 110.95
03	Thibodaux	Family and Children	14-18 Years, Male	$ 79.25	0.9959	0.9988	0.9052	1.0291	0.9337	$ 68.57	4.5%	$ 71.67	$ 88.14	1.0124	0.9989	0.8992	1.0160	0.9569	$ 77.92
03	Thibodaux	Family and Children	19-44 Years, Female	$ 231.26	0.9965	0.9987	0.9237	1.0378	0.9182	$ 202.58	4.6%	$ 211.81	$ 240.68	1.0169	0.9992	0.9220	1.0231	0.9446	$ 217.92
03	Thibodaux	Family and Children	19-44 Years, Male	$ 232.79	0.9969	0.9985	0.9095	1.0481	0.9199	$ 203.18	4.6%	$ 212.49	$ 252.95	1.0221	0.9992	0.9331	1.0359	0.9423	$ 235.27
03	Thibodaux	Family and Children	45+ Years, Female	$ 486.76	0.9978	0.9983	0.8988	1.0550	0.9242	$ 424.92	3.6%	$ 440.42	$ 438.63	1.0162	0.9992	0.8894	1.0307	0.9478	$ 386.94
03	Thibodaux	Family and Children	45+ Years, Male	$ 400.49	0.9973	0.9984	0.8802	1.0552	0.9247	$ 342.46	4.0%	$ 356.20	$ 395.82	1.0177	0.9993	0.9025	1.0317	0.9457	$ 354.49
03	Thibodaux	Foster Care Children	Foster Care, All Ages Male & Female	$ 194.34	0.9999	0.9985	0.8856	1.0444	0.9349	$ 167.81	3.3%	$ 173.36	$ 150.75	1.0216	0.9986	0.8615	1.0095	0.9656	$ 129.16
03	Thibodaux	Breast and Cervical Cancer	BCC, All Ages Female	$ 2,608.98	0.9986	0.9977	0.9414	1.1033	0.9080	$ 2,451.31	8.2%	$ 2,652.21	$ 2,388.55	1.0212	0.9997	0.9369	1.0117	0.9707	$ 2,243.36
03	Thibodaux	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 5,161.24	1.0000	1.0000	1.0000	1.0000	0.9157	$ 4,726.06	0.0%	$ 4,726.06	$ 5,228.02	1.0000	1.0000	1.0000	1.0000	0.9376	$ 4,901.60
04	LaFayette	SSI	0-2 Months, Male and Female	$ 13,089.55	1.0016	0.9969	0.9933	1.0532	0.9408	$ 12,863.08	2.2%	$ 13,143.48	$ 19,928.70	1.0646	0.9991	0.9980	1.0704	0.9567	$ 21,662.74
04	LaFayette	SSI	3-11 Months, Male and Female	$ 3,087.66	1.0005	0.9980	0.9088	1.0356	0.9515	$ 2,760.93	2.7%	$ 2,835.45	$ 3,925.88	1.0518	0.9994	0.9499	1.0510	0.9624	$ 3,965.28
04	LaFayette	SSI	1-5 Years, Male and Female	$ 944.13	0.9995	0.9990	0.8718	1.0121	0.9677	$ 805.00	3.7%	$ 834.99	$ 781.42	1.0401	0.9994	0.9277	1.0238	0.9735	$ 751.07
04	LaFayette	SSI	6-13 Years, Male and Female	$ 311.16	0.9993	0.9991	0.8283	1.0074	0.9605	$ 248.97	3.5%	$ 257.68	$ 326.54	1.0181	0.9995	0.8094	0.9998	0.9790	$ 263.26
04	LaFayette	SSI	14-18 Years, Male and Female	$ 276.47	0.9992	0.9990	0.8300	1.0051	0.9512	$ 218.98	3.8%	$ 227.23	$ 321.95	1.0351	0.9994	0.8949	1.0247	0.9660	$ 295.03
04	LaFayette	SSI	19-44 Years, Male and Female	$ 529.25	0.9996	0.9986	0.8757	1.0146	0.9390	$ 440.81	3.8%	$ 457.68	$ 520.93	1.0272	0.9994	0.8672	1.0094	0.9636	$ 451.07
04	LaFayette	SSI	45+ Years, Male and Female	$ 882.83	0.9995	0.9986	0.8567	1.0116	0.9421	$ 719.41	3.7%	$ 746.13	$ 837.28	1.0247	0.9992	0.8505	1.0020	0.9667	$ 706.17
04	LaFayette	Family and Children	0-2 Months, Male and Female	$ 1,440.57	1.0018	0.9972	0.9868	1.0504	0.9128	$ 1,361.53	2.1%	$ 1,390.39	$ 1,227.45	1.0475	0.9989	0.9875	1.0586	0.9278	$ 1,245.61
04	LaFayette	Family and Children	3-11 Months, Male and Female	$ 280.57	0.9970	0.9987	0.8650	1.0132	0.9466	$ 231.77	3.4%	$ 239.55	$ 256.18	1.0178	0.9989	0.8903	1.0155	0.9557	$ 225.01
04	LaFayette	Family and Children	1-5 Years, Male and Female	$ 113.45	0.9962	0.9988	0.8650	1.0056	0.9442	$ 92.71	3.8%	$ 96.21	$ 112.44	1.0110	0.9987	0.8680	1.0032	0.9580	$ 94.71
04	LaFayette	Family and Children	6-13 Years, Male and Female	$ 72.78	0.9957	0.9989	0.8602	1.0014	0.9463	$ 59.01	3.9%	$ 61.30	$ 76.80	1.0081	0.9987	0.8579	0.9980	0.9635	$ 63.77
04	LaFayette	Family and Children	14-18 Years, Female	$ 109.54	0.9958	0.9989	0.8942	1.0010	0.9328	$ 90.98	4.3%	$ 94.92	$ 111.84	1.0108	0.9989	0.8882	0.9926	0.9548	$ 95.05
04	LaFayette	Family and Children	14-18 Years, Male	$ 74.76	0.9962	0.9988	0.8967	1.0038	0.9343	$ 62.55	4.2%	$ 65.17	$ 77.01	1.0122	0.9988	0.8927	0.9964	0.9553	$ 66.16
04	LaFayette	Family and Children	19-44 Years, Female	$ 229.84	0.9965	0.9987	0.9060	1.0058	0.9226	$ 192.30	4.3%	$ 200.56	$ 217.94	1.0148	0.9991	0.9039	0.9956	0.9474	$ 188.39
04	LaFayette	Family and Children	19-44 Years, Male	$ 222.53	0.9961	0.9989	0.8631	1.0023	0.9317	$ 178.48	4.3%	$ 186.13	$ 222.10	1.0152	0.9991	0.8907	0.9970	0.9485	$ 189.75
04	LaFayette	Family and Children	45+ Years, Female	$ 446.84	0.9967	0.9986	0.8692	1.0066	0.9311	$ 362.30	3.9%	$ 376.32	$ 387.22	1.0095	0.9991	0.8522	0.9909	0.9575	$ 315.76
04	LaFayette	Family and Children	45+ Years, Male	$ 462.09	0.9966	0.9985	0.8626	1.0040	0.9312	$ 370.86	3.9%	$ 385.43	$ 392.94	1.0116	0.9987	0.8501	0.9987	0.9520	$ 320.87
04	LaFayette	Foster Care Children	Foster Care, All Ages Male & Female	$ 159.10	0.9993	0.9989	0.8697	1.0052	0.9426	$ 130.87	4.1%	$ 136.22	$ 138.98	1.0234	0.9988	0.8656	0.9981	0.9669	$ 118.67
04	LaFayette	Breast and Cervical Cancer	BCC, All Ages Female	$ 2,218.99	0.9989	0.9980	0.9248	0.9831	0.9097	$ 1,829.65	6.5%	$ 1,948.10	$ 2,829.46	1.0242	0.9994	0.9276	0.9293	0.9629	$ 2,403.90
04	LaFayette	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 4,534.76	1.0000	1.0000	1.0000	1.0000	0.9157	$ 4,152.41	0.0%	$ 4,152.41	$ 4,592.04	1.0000	1.0000	1.0000	1.0000	0.9376	$ 4,305.32

Attachment B

CCN-S Benchmark PMPM Development

				3/1/2012-12/31/2012					
				Weighted FY09 and FY10 PMPM at FY10		Projected FFS PMPM	PMPM Post Smoothing w/Statewide		CCN-S Benchmark PMPM
DHH Administrative Region	Region Description	COA Description	RC Description	PMPM or Cost/Delivery	Trend	PMPM or Cost/Delivery	PMPM or Cost/Delivery	Catastrophic Limit Adjustment	PMPM or Cost/Delivery
02	Baton Rouge	SSI	0-2 Months, Male and Female	$ 19,199.56	2.12%	$ 20,269.00	$ 18,138.86	0.9218	$ 16,720.82
02	Baton Rouge	SSI	3-11 Months, Male and Female	$ 4,040.16	2.51%	$ 4,306.85	$ 3,925.73	0.9218	$ 3,618.81
02	Baton Rouge	SSI	1-5 Years, Male and Female	$ 590.64	3.52%	$ 645.85	$ 696.02	0.9218	$ 641.60
02	Baton Rouge	SSI	6-13 Years, Male and Female	$ 195.78	3.45%	$ 213.71	$ 220.35	0.9218	$ 203.12
02	Baton Rouge	SSI	14-18 Years, Male and Female	$ 195.00	3.76%	$ 214.51	$ 234.21	0.9218	$ 215.89
02	Baton Rouge	SSI	19-44 Years, Male and Female	$ 539.91	3.51%	$ 590.22	$ 590.22	0.9218	$ 544.07
02	Baton Rouge	SSI	45+ Years, Male and Female	$ 773.46	3.97%	$ 855.31	$ 855.31	0.9218	$ 788.42
02	Baton Rouge	Family and Children	0-2 Months, Male and Female	$ 1,330.82	2.04%	$ 1,402.05	$ 1,402.05	0.9551	$ 1,339.07
02	Baton Rouge	Family and Children	3-11 Months, Male and Female	$ 205.04	3.31%	$ 223.00	$ 223.00	0.9551	$ 212.99
02	Baton Rouge	Family and Children	1-5 Years, Male and Female	$ 81.63	3.87%	$ 90.05	$ 90.05	0.9551	$ 86.00
02	Baton Rouge	Family and Children	6-13 Years, Male and Female	$ 53.02	3.87%	$ 58.48	$ 58.48	0.9551	$ 55.86
02	Baton Rouge	Family and Children	14-18 Years, Female	$ 82.51	4.33%	$ 92.07	$ 92.07	0.9551	$ 87.93
02	Baton Rouge	Family and Children	14-18 Years, Male	$ 57.86	4.24%	$ 64.41	$ 64.41	0.9551	$ 61.51
02	Baton Rouge	Family and Children	19-44 Years, Female	$ 185.10	4.40%	$ 206.87	$ 206.87	0.9551	$ 197.58
02	Baton Rouge	Family and Children	19-44 Years, Male	$ 229.03	3.99%	$ 253.37	$ 233.26	0.9551	$ 222.78
02	Baton Rouge	Family and Children	45+ Years, Female	$ 328.94	4.07%	$ 364.66	$ 384.36	0.9551	$ 367.09
02	Baton Rouge	Family and Children	45+ Years, Male	$ 336.48	3.80%	$ 370.54	$ 448.61	0.9551	$ 428.45
02	Baton Rouge	Foster Care Children	Foster Care, All Ages Male & Female	$ 109.64	4.21%	$ 121.98	$ 143.40	0.9388	$ 134.63
02	Baton Rouge	Breast and Cervical Cancer	BCC, All Ages Female	$ 1,756.47	7.65%	$ 2,124.74	$ 2,080.95	0.9100	$ 1,893.60
02	Baton Rouge	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 4,877.66	0.00%	$ 4,877.66	$ 4,877.66	1.0000	$ 4,877.66
03	Thibodaux	SSI	0-2 Months, Male and Female	$ 17,363.65	2.02%	$ 18,286.11	$ 18,138.86	0.9218	$ 16,720.82
03	Thibodaux	SSI	3-11 Months, Male and Female	$ 3,351.66	2.50%	$ 3,572.76	$ 3,925.73	0.9218	$ 3,618.81
03	Thibodaux	SSI	1-5 Years, Male and Female	$ 465.44	3.71%	$ 511.31	$ 696.02	0.9218	$ 641.60
03	Thibodaux	SSI	6-13 Years, Male and Female	$ 156.53	4.20%	$ 174.08	$ 220.35	0.9218	$ 203.12
03	Thibodaux	SSI	14-18 Years, Male and Female	$ 174.94	4.48%	$ 195.91	$ 234.21	0.9218	$ 215.89
03	Thibodaux	SSI	19-44 Years, Male and Female	$ 408.31	4.48%	$ 457.30	$ 457.30	0.9218	$ 421.54
03	Thibodaux	SSI	45+ Years, Male and Female	$ 743.13	4.50%	$ 832.55	$ 832.55	0.9218	$ 767.44
03	Thibodaux	Family and Children	0-2 Months, Male and Female	$ 1,115.71	2.24%	$ 1,181.46	$ 1,181.46	0.9551	$ 1,128.38
03	Thibodaux	Family and Children	3-11 Months, Male and Female	$ 205.12	3.56%	$ 224.51	$ 224.51	0.9551	$ 214.42
03	Thibodaux	Family and Children	1-5 Years, Male and Female	$ 98.15	4.01%	$ 108.65	$ 108.65	0.9551	$ 103.77
03	Thibodaux	Family and Children	6-13 Years, Male and Female	$ 65.23	4.14%	$ 72.44	$ 72.44	0.9551	$ 69.18
03	Thibodaux	Family and Children	14-18 Years, Female	$ 110.99	4.55%	$ 124.50	$ 124.50	0.9551	$ 118.90
03	Thibodaux	Family and Children	14-18 Years, Male	$ 75.42	4.47%	$ 84.45	$ 84.45	0.9551	$ 80.66
03	Thibodaux	Family and Children	19-44 Years, Female	$ 215.47	4.62%	$ 242.14	$ 242.14	0.9551	$ 231.26
03	Thibodaux	Family and Children	19-44 Years, Male	$ 226.16	4.45%	$ 253.09	$ 233.26	0.9551	$ 222.78
03	Thibodaux	Family and Children	45+ Years, Female	$ 408.33	3.98%	$ 451.65	$ 384.36	0.9551	$ 367.09
03	Thibodaux	Family and Children	45+ Years, Male	$ 355.18	4.30%	$ 396.02	$ 448.61	0.9551	$ 428.45
03	Thibodaux	Foster Care Children	Foster Care, All Ages Male & Female	$ 146.84	3.81%	$ 161.72	$ 143.40	0.9388	$ 134.63
03	Thibodaux	Breast and Cervical Cancer	BCC, All Ages Female	$ 2,406.90	8.26%	$ 2,954.58	$ 2,080.95	0.9100	$ 1,893.60
03	Thibodaux	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 4,831.38	0.00%	$ 4,831.38	$ 4,831.38	1.0000	$ 4,831.38
04	LaFayette	SSI	0-2 Months, Male and Female	$ 18,255.04	2.11%	$ 19,267.75	$ 18,138.86	0.9218	$ 16,720.82
04	LaFayette	SSI	3-11 Months, Male and Female	$ 3,513.35	2.65%	$ 3,758.54	$ 3,925.73	0.9218	$ 3,618.81
04	LaFayette	SSI	1-5 Years, Male and Female	$ 784.64	3.72%	$ 862.30	$ 696.02	0.9218	$ 641.60
04	LaFayette	SSI	6-13 Years, Male and Female	$ 261.03	3.62%	$ 286.14	$ 220.35	0.9218	$ 203.12
04	LaFayette	SSI	14-18 Years, Male and Female	$ 267.91	3.55%	$ 293.17	$ 234.21	0.9218	$ 215.89
04	LaFayette	SSI	19-44 Years, Male and Female	$ 453.71	3.94%	$ 501.40	$ 501.40	0.9218	$ 462.19
04	LaFayette	SSI	45+ Years, Male and Female	$ 722.16	3.86%	$ 796.45	$ 796.45	0.9218	$ 734.18
04	LaFayette	Family and Children	0-2 Months, Male and Female	$ 1,303.52	2.17%	$ 1,377.83	$ 1,377.83	0.9551	$ 1,315.93
04	LaFayette	Family and Children	3-11 Months, Male and Female	$ 230.82	3.41%	$ 251.73	$ 251.73	0.9551	$ 240.42
04	LaFayette	Family and Children	1-5 Years, Male and Female	$ 95.31	3.83%	$ 105.04	$ 105.04	0.9551	$ 100.32
04	LaFayette	Family and Children	6-13 Years, Male and Female	$ 62.79	3.90%	$ 69.31	$ 69.31	0.9551	$ 66.20
04	LaFayette	Family and Children	14-18 Years, Female	$ 95.00	4.39%	$ 106.15	$ 106.15	0.9551	$ 101.38
04	LaFayette	Family and Children	14-18 Years, Male	$ 65.76	4.27%	$ 73.26	$ 73.26	0.9551	$ 69.97
04	LaFayette	Family and Children	19-44 Years, Female	$ 193.26	4.40%	$ 216.00	$ 216.00	0.9551	$ 206.29
04	LaFayette	Family and Children	19-44 Years, Male	$ 188.30	4.28%	$ 209.84	$ 233.26	0.9551	$ 222.78
04	LaFayette	Family and Children	45+ Years, Female	$ 339.98	3.98%	$ 376.07	$ 384.36	0.9551	$ 367.09
04	LaFayette	Family and Children	45+ Years, Male	$ 346.70	3.80%	$ 381.77	$ 448.61	0.9551	$ 428.45
04	LaFayette	Foster Care Children	Foster Care, All Ages Male & Female	$ 125.69	4.15%	$ 139.62	$ 143.40	0.9388	$ 134.63
04	LaFayette	Breast and Cervical Cancer	BCC, All Ages Female	$ 2,221.58	6.77%	$ 2,631.11	$ 2,080.95	0.9100	$ 1,893.60
04	LaFayette	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 4,244.15	0.00%	$ 4,244.15	$ 4,244.15	1.0000	$ 4,244.15

Attachment B

CCN-S Benchmark PMPM Development

				5/1/2012-12/31/2012									5/1/2012-12/31/2012						
				State Fiscal Year 2009 Rate Development									State Fiscal Year 2010 Rate Development						
				FY09 CCN-S Base PMPM	Adjustments					FY09 CCN-S PMPM Post Adjustments		Projected FY10 CCN-S PMPM	FY10 CCN-S Base PMPM	Adjustments					FY10 CCN-S PMPM Post Adjustments
DHH Administrative Region	Region Description	COA Description	RC Description	PMPM or Cost/Delivery	Completion Factor	Program Integrity Recoupments (Fraud & Abuse)	Rx Rebate	IP and OP Hospital Cost Settlements	Fee Schedule Changes	PMPM or Cost/Delivery	Trend to FY10	PMPM or Cost/Delivery	PMPM or Cost/Delivery	Completion Factor	Program Integrity Recoupments (Fraud & Abuse)	Rx Rebate	IP and OP Hospital Cost Settlements	Fee Schedule Changes	PMPM or Cost/Delivery
05	Lake Charles	SSI	0-2 Months, Male and Female	$ 20,365.07	1.0018	0.9969	0.9934	1.0110	0.9419	$ 19,240.00	2.1%	$ 19,635.07	$ 10,915.21	1.0588	0.9986	0.9875	1.0090	0.9617	$ 11,058.53
05	Lake Charles	SSI	3-11 Months, Male and Female	$ 4,192.50	1.0004	0.9983	0.8872	1.0082	0.9562	$ 3,581.09	2.6%	$ 3,675.18	$ 2,740.76	1.0360	0.9992	0.8712	1.0062	0.9707	$ 2,414.40
05	Lake Charles	SSI	1-5 Years, Male and Female	$ 888.77	0.9992	0.9992	0.8402	1.0070	0.9696	$ 727.99	3.8%	$ 755.33	$ 925.07	1.0251	0.9995	0.8448	1.0038	0.9791	$ 786.91
05	Lake Charles	SSI	6-13 Years, Male and Female	$ 197.07	0.9994	0.9989	0.8674	1.0121	0.9503	$ 164.11	4.1%	$ 170.91	$ 287.65	1.0359	0.9993	0.9030	1.0061	0.9686	$ 262.05
05	Lake Charles	SSI	14-18 Years, Male and Female	$ 208.93	0.9994	0.9989	0.8605	1.0124	0.9448	$ 171.66	4.2%	$ 178.81	$ 227.91	1.0237	0.9994	0.8486	1.0037	0.9710	$ 192.84
05	Lake Charles	SSI	19-44 Years, Male and Female	$ 440.11	0.9995	0.9988	0.8663	1.0131	0.9389	$ 361.97	4.1%	$ 376.94	$ 473.56	1.0313	0.9994	0.8947	1.0064	0.9621	$ 422.83
05	Lake Charles	SSI	45+ Years, Male and Female	$ 800.08	0.9996	0.9985	0.8734	1.0168	0.9397	$ 666.40	4.0%	$ 693.01	$ 831.28	1.0301	0.9993	0.8789	1.0068	0.9644	$ 730.30
05	Lake Charles	Family and Children	0-2 Months, Male and Female	$ 1,366.69	1.0014	0.9973	0.9823	1.0094	0.9161	$ 1,239.72	2.2%	$ 1,267.53	$ 1,353.61	1.0474	0.9990	0.9850	1.0089	0.9293	$ 1,307.94
05	Lake Charles	Family and Children	3-11 Months, Male and Female	$ 318.00	0.9966	0.9990	0.8375	1.0051	0.9529	$ 253.95	3.3%	$ 262.32	$ 283.00	1.0156	0.9990	0.8668	1.0038	0.9587	$ 239.51
05	Lake Charles	Family and Children	1-5 Years, Male and Female	$ 133.43	0.9959	0.9991	0.8373	1.0073	0.9490	$ 106.24	3.8%	$ 110.30	$ 128.45	1.0086	0.9988	0.8515	1.0028	0.9610	$ 106.19
05	Lake Charles	Family and Children	6-13 Years, Male and Female	$ 80.32	0.9958	0.9990	0.8677	1.0082	0.9440	$ 65.99	4.0%	$ 68.65	$ 82.26	1.0091	0.9987	0.8675	1.0026	0.9620	$ 69.36
05	Lake Charles	Family and Children	14-18 Years, Female	$ 119.48	0.9958	0.9990	0.8902	1.0110	0.9342	$ 99.93	4.4%	$ 104.37	$ 125.42	1.0108	0.9991	0.8878	1.0032	0.9568	$ 107.94
05	Lake Charles	Family and Children	14-18 Years, Male	$ 80.29	0.9960	0.9989	0.9011	1.0110	0.9312	$ 67.76	4.5%	$ 70.82	$ 82.47	1.0124	0.9989	0.8951	1.0035	0.9546	$ 71.51
05	Lake Charles	Family and Children	19-44 Years, Female	$ 247.30	0.9966	0.9987	0.9085	1.0170	0.9213	$ 209.51	4.5%	$ 218.89	$ 252.91	1.0173	0.9994	0.9107	1.0056	0.9468	$ 222.95
05	Lake Charles	Family and Children	19-44 Years, Male	$ 270.59	0.9976	0.9984	0.9181	1.0161	0.9171	$ 230.59	4.1%	$ 240.09	$ 200.78	1.0130	0.9991	0.8977	1.0042	0.9498	$ 173.98
05	Lake Charles	Family and Children	45+ Years, Female	$ 410.32	0.9964	0.9988	0.8541	1.0167	0.9306	$ 330.01	4.2%	$ 343.93	$ 455.81	1.0196	0.9992	0.8845	1.0061	0.9461	$ 390.95
05	Lake Charles	Family and Children	45+ Years, Male	$ 545.67	0.9983	0.9982	0.9160	1.0152	0.9194	$ 464.87	3.6%	$ 481.75	$ 517.91	1.0184	0.9989	0.9119	1.0070	0.9436	$ 456.55
05	Lake Charles	Foster Care Children	Foster Care, All Ages Male & Female	$ 184.02	0.9993	0.9989	0.8451	1.0134	0.9427	$ 148.28	4.1%	$ 154.34	$ 174.94	1.0208	0.9991	0.8383	1.0040	0.9659	$ 145.05
05	Lake Charles	Breast and Cervical Cancer	BCC, All Ages Female	$ 1,770.24	0.9985	0.9978	0.9313	1.0628	0.9096	$ 1,587.99	8.2%	$ 1,718.87	$ 1,870.43	1.0217	0.9996	0.9295	1.0138	0.9727	$ 1,750.91
05	Lake Charles	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 4,801.23	1.0000	1.0000	1.0000	1.0000	0.9157	$ 4,396.41	0.0%	$ 4,396.41	$ 4,685.03	1.0000	1.0000	1.0000	1.0000	0.9376	$ 4,392.51
06	Alexandria	SSI	0-2 Months, Male and Female	$ 22,905.33	1.0018	0.9969	0.9949	1.0116	0.9411	$ 21,666.57	2.0%	$ 22,109.83	$ 13,524.38	1.0593	0.9981	0.9951	1.0116	0.9605	$ 13,825.77
06	Alexandria	SSI	3-11 Months, Male and Female	$ 3,581.39	1.0010	0.9976	0.9277	1.0079	0.9478	$ 3,169.39	2.3%	$ 3,241.15	$ 4,569.08	1.0563	0.9995	0.9638	1.0124	0.9614	$ 4,525.23
06	Alexandria	SSI	1-5 Years, Male and Female	$ 761.28	1.0000	0.9985	0.8938	0.9968	0.9557	$ 647.21	3.3%	$ 668.48	$ 460.20	1.0305	0.9993	0.8903	1.0028	0.9729	$ 411.61
06	Alexandria	SSI	6-13 Years, Male and Female	$ 262.01	0.9997	0.9987	0.8725	0.9954	0.9524	$ 216.39	3.4%	$ 223.70	$ 259.80	1.0270	0.9993	0.8626	1.0031	0.9722	$ 224.32
06	Alexandria	SSI	14-18 Years, Male and Female	$ 239.78	0.9994	0.9990	0.8522	0.9939	0.9495	$ 192.53	3.8%	$ 199.88	$ 226.10	1.0206	0.9994	0.8462	1.0010	0.9696	$ 189.41
06	Alexandria	SSI	19-44 Years, Male and Female	$ 435.63	0.9997	0.9986	0.8860	0.9921	0.9385	$ 358.76	3.9%	$ 372.86	$ 424.39	1.0278	0.9994	0.8766	1.0034	0.9624	$ 368.99
06	Alexandria	SSI	45+ Years, Male and Female	$ 864.61	0.9997	0.9985	0.8716	0.9889	0.9426	$ 701.09	3.7%	$ 726.89	$ 818.22	1.0283	0.9994	0.8646	1.0038	0.9653	$ 704.36
06	Alexandria	Family and Children	0-2 Months, Male and Female	$ 1,410.60	1.0018	0.9972	0.9887	1.0087	0.9156	$ 1,286.78	2.1%	$ 1,314.36	$ 1,580.72	1.0499	0.9991	0.9920	1.0126	0.9280	$ 1,545.69
06	Alexandria	Family and Children	3-11 Months, Male and Female	$ 283.62	0.9972	0.9987	0.8803	0.9986	0.9462	$ 234.95	3.3%	$ 242.74	$ 255.67	1.0182	0.9990	0.9001	1.0038	0.9563	$ 224.72
06	Alexandria	Family and Children	1-5 Years, Male and Female	$ 123.01	0.9965	0.9988	0.8879	0.9930	0.9445	$ 101.95	3.8%	$ 105.83	$ 130.28	1.0112	0.9989	0.8782	1.0012	0.9602	$ 111.09
06	Alexandria	Family and Children	6-13 Years, Male and Female	$ 78.55	0.9959	0.9990	0.8776	0.9917	0.9470	$ 64.41	4.0%	$ 66.96	$ 84.74	1.0078	0.9989	0.8687	1.0000	0.9647	$ 71.48
06	Alexandria	Family and Children	14-18 Years, Female	$ 123.28	0.9961	0.9989	0.9076	0.9866	0.9326	$ 102.44	4.4%	$ 106.94	$ 125.13	1.0118	0.9992	0.9009	1.0000	0.9548	$ 108.82
06	Alexandria	Family and Children	14-18 Years, Male	$ 82.63	0.9963	0.9989	0.9098	0.9889	0.9338	$ 69.08	4.3%	$ 72.09	$ 84.47	1.0130	0.9991	0.9058	1.0004	0.9561	$ 74.08
06	Alexandria	Family and Children	19-44 Years, Female	$ 242.36	0.9968	0.9987	0.9146	0.9852	0.9220	$ 200.44	4.3%	$ 209.15	$ 241.22	1.0169	0.9994	0.9109	1.0012	0.9457	$ 211.45
06	Alexandria	Family and Children	19-44 Years, Male	$ 270.26	0.9970	0.9987	0.8939	0.9893	0.9262	$ 220.39	4.1%	$ 229.40	$ 240.19	1.0149	0.9991	0.8984	1.0008	0.9468	$ 207.35
06	Alexandria	Family and Children	45+ Years, Female	$ 592.04	0.9984	0.9982	0.9150	0.9924	0.9219	$ 493.96	3.4%	$ 510.81	$ 478.69	1.0142	0.9992	0.8682	1.0018	0.9505	$ 401.07
06	Alexandria	Family and Children	45+ Years, Male	$ 680.31	0.9983	0.9981	0.9053	0.9881	0.9215	$ 558.81	3.4%	$ 577.96	$ 593.98	1.0205	0.9993	0.8837	1.0040	0.9444	$ 507.60
06	Alexandria	Foster Care Children	Foster Care, All Ages Male & Female	$ 147.31	0.9997	0.9987	0.8928	0.9945	0.9382	$ 122.51	3.8%	$ 127.18	$ 125.51	1.0242	0.9990	0.8772	1.0009	0.9643	$ 108.71
06	Alexandria	Breast and Cervical Cancer	BCC, All Ages Female	$ 2,525.48	0.9988	0.9976	0.9411	0.9216	0.9157	$ 1,998.58	7.3%	$ 2,143.66	$ 1,920.51	1.0249	0.9995	0.8977	0.9963	0.9686	$ 1,704.25
06	Alexandria	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 4,935.96	1.0000	1.0000	1.0000	1.0000	0.9157	$ 4,519.77	0.0%	$ 4,519.77	$ 4,787.26	1.0000	1.0000	1.0000	1.0000	0.9376	$ 4,488.35
07	Shreveport	SSI	0-2 Months, Male and Female	$ 7,945.94	1.0014	0.9969	0.9932	1.2397	0.9407	$ 9,188.18	2.3%	$ 9,399.34	$ 15,691.88	1.0628	0.9987	0.9960	0.9984	0.9586	$ 15,877.92
07	Shreveport	SSI	3-11 Months, Male and Female	$ 3,437.82	1.0011	0.9975	0.9430	1.2489	0.9447	$ 3,819.33	2.2%	$ 3,904.87	$ 4,285.95	1.0509	0.9991	0.9483	1.0152	0.9635	$ 4,173.78
07	Shreveport	SSI	1-5 Years, Male and Female	$ 438.83	0.9998	0.9986	0.8827	1.1096	0.9509	$ 408.05	3.4%	$ 421.92	$ 479.83	1.0373	0.9994	0.9052	1.0356	0.9683	$ 451.53
07	Shreveport	SSI	6-13 Years, Male and Female	$ 189.30	0.9995	0.9988	0.8601	1.0763	0.9495	$ 166.10	3.7%	$ 172.24	$ 204.26	1.0249	0.9994	0.8491	1.0477	0.9713	$ 180.78
07	Shreveport	SSI	14-18 Years, Male and Female	$ 285.55	0.9995	0.9989	0.8353	1.0931	0.9490	$ 247.01	3.3%	$ 255.16	$ 319.88	1.0271	0.9996	0.8462	1.0397	0.9673	$ 279.49
07	Shreveport	SSI	19-44 Years, Male and Female	$ 474.08	1.0000	0.9984	0.9031	1.1360	0.9369	$ 454.87	3.5%	$ 470.80	$ 499.76	1.0361	0.9996	0.8987	1.0513	0.9601	$ 469.51
07	Shreveport	SSI	45+ Years, Male and Female	$ 727.48	0.9998	0.9983	0.8878	1.1130	0.9387	$ 716.09	3.6%	$ 741.88	$ 745.94	1.0325	0.9994	0.8849	1.0708	0.9626	$ 702.11
07	Shreveport	Family and Children	0-2 Months, Male and Female	$ 1,427.43	1.0020	0.9971	0.9902	1.2681	0.9107	$ 1,630.80	2.0%	$ 1,663.22	$ 1,334.83	1.0500	0.9990	0.9921	1.0036	0.9266	$ 1,291.73
07	Shreveport	Family and Children	3-11 Months, Male and Female	$ 251.19	0.9979	0.9985	0.9044	1.1154	0.9348	$ 236.00	3.2%	$ 243.48	$ 230.24	1.0226	0.9992	0.9163	1.0305	0.9523	$ 211.56
07	Shreveport	Family and Children	1-5 Years, Male and Female	$ 100.54	0.9967	0.9988	0.8975	1.0611	0.9364	$ 89.24	3.9%	$ 92.68	$ 105.79	1.0156	0.9991	0.8931	1.0426	0.9544	$ 95.40
07	Shreveport	Family and Children	6-13 Years, Male and Female	$ 60.25	0.9961	0.9990	0.8819	1.0366	0.9415	$ 51.60	4.0%	$ 53.66	$ 64.63	1.0108	0.9990	0.8772	1.0440	0.9600	$ 57.38
07	Shreveport	Family and Children	14-18 Years, Female	$ 107.97	0.9962	0.9989	0.9077	1.0397	0.9293	$ 94.23	4.3%	$ 98.33	$ 109.40	1.0130	0.9993	0.8999	1.0758	0.9530	$ 102.18
07	Shreveport	Family and Children	14-18 Years, Male	$ 64.68	0.9964	0.9988	0.9153	1.0480	0.9298	$ 57.42	4.3%	$ 59.89	$ 64.56	1.0138	0.9991	0.9056	1.0616	0.9540	$ 59.98
07	Shreveport	Family and Children	19-44 Years, Female	$ 224.19	0.9973	0.9985	0.9215	1.0814	0.9167	$ 203.92	4.1%	$ 212.25	$ 218.96	1.0196	0.9994	0.9200	1.0864	0.9434	$ 210.37
07	Shreveport	Family and Children	19-44 Years, Male	$ 201.31	0.9979	0.9985	0.9001	1.1151	0.9205	$ 185.32	3.6%	$ 191.91	$ 224.74	1.0223	0.9993	0.9186	1.0595	0.9429	$ 210.70
07	Shreveport	Family and Children	45+ Years, Female	$ 409.07	0.9974	0.9985	0.8881	1.0909	0.9241	$ 364.75	3.6%	$ 378.02	$ 351.84	1.0173	0.9993	0.8894	1.0929	0.9478	$ 329.48
07	Shreveport	Family and Children	45+ Years, Male	$ 544.90	0.9971	0.9986	0.8398	1.0869	0.9335	$ 462.36	3.3%	$ 477.41	$ 514.68	1.0106	0.9993	0.8348	1.0819	0.9530	$ 447.41
07	Shreveport	Foster Care Children	Foster Care, All Ages Male & Female	$ 123.20	0.9992	0.9990	0.8511	1.0379	0.9420	$ 102.34	4.0%	$ 106.44	$ 159.12	1.0288	0.9992	0.8774	1.0466	0.9596	$ 144.13
07	Shreveport	Breast and Cervical Cancer	BCC, All Ages Female	$ 2,088.60	0.9990	0.9979	0.9058	1.0223	0.9261	$ 1,785.62	6.0%	$ 1,891.89	$ 1,793.48	1.0191	0.9996	0.8817	1.3211	0.9748	$ 2,074.21
07	Shreveport	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 5,183.04	1.0000	1.0000	1.0000	1.0000	0.9157	$ 4,746.02	0.0%	$ 4,746.02	$ 5,217.27	1.0000	1.0000	1.0000	1.0000	0.9376	$ 4,891.52
08	Monroe	SSI	0-2 Months, Male and Female	$ 13,874.36	1.0017	0.9970	0.9901	0.9917	0.9397	$ 12,783.02	2.1%	$ 13,056.83	$ 18,653.19	1.0609	0.9986	0.9914	1.0197	0.9569	$ 19,116.51
08	Monroe	SSI	3-11 Months, Male and Female	$ 2,517.17	1.0000	0.9984	0.8900	1.0095	0.9571	$ 2,160.83	3.3%	$ 2,232.66	$ 2,962.57	1.0418	0.9992	0.9069	1.0137	0.9675	$ 2,742.84
08	Monroe	SSI	1-5 Years, Male and Female	$ 1,154.36	1.0003	0.9984	0.9129	1.0067	0.9567	$ 1,013.58	3.2%	$ 1,046.26	$ 722.27	1.0325	0.9995	0.8830	1.0083	0.9757	$ 647.49
08	Monroe	SSI	6-13 Years, Male and Female	$ 289.58	1.0002	0.9984	0.9009	1.0136	0.9501	$ 250.84	3.4%	$ 259.39	$ 233.90	1.0305	0.9994	0.8866	1.0074	0.9726	$ 209.24
08	Monroe	SSI	14-18 Years, Male and Female	$ 214.41	0.9994	0.9988	0.8708	1.0299	0.9430	$ 181.02	4.4%	$ 188.91	$ 258.74	1.0270	0.9995	0.8589	1.0077	0.9690	$ 222.76
08	Monroe	SSI	19-44 Years, Male and Female	$ 499.40	0.9997	0.9987	0.8555	1.0205	0.9420	$ 410.03	3.7%	$ 425.14	$ 497.29	1.0273	0.9996	0.8565	1.0088	0.9635	$ 425.16
08	Monroe	SSI	45+ Years, Male and Female	$ 901.33	0.9997	0.9985	0.8686	1.0326	0.9404	$ 758.89	3.9%	$ 788.49	$ 822.18	1.0285	0.9994	0.8629	1.0089	0.9649	$ 709.87
08	Monroe	Family and Children	0-2 Months, Male and Female	$ 1,625.33	1.0016	0.9972	0.9845	0.9944	0.9142	$ 1,452.92	2.2%	$ 1,484.65	$ 1,533.32	1.0482	0.9988	0.9888	1.0190	0.9274	$ 1,500.17
08	Monroe	Family and Children	3-11 Months, Male and Female	$ 380.96	0.9978	0.9987	0.8640	1.0052	0.9445	$ 311.42	3.1%	$ 320.93	$ 309.17	1.0115	0.9992	0.8464	1.0057	0.9633	$ 256.25
08	Monroe	Family and Children	1-5 Years, Male and Female	$ 143.36	0.9962	0.9991	0.8453	1.0194	0.9493	$ 116.73	3.8%	$ 121.13	$ 146.66	1.0075	0.9992	0.8367	1.0037	0.9652	$ 119.68
08	Monroe	Family and Children	6-13 Years, Male and Female	$ 77.79	0.9960	0.9990	0.8677	1.0214	0.9474	$ 65.00	4.0%	$ 67.57	$ 80.91	1.0078	0.9991	0.8573	1.0027	0.9665	$ 67.68
08	Monroe	Family and Children	14-18 Years, Female	$ 120.99	0.9962	0.9990	0.8972	1.0278	0.9355	$ 103.87	4.3%	$ 108.34	$ 122.54	1.0122	0.9993	0.8929	1.0036	0.9582	$ 106.44
08	Monroe	Family and Children	14-18 Years, Male	$ 80.26	0.9965	0.9988	0.9073	1.0278	0.9338	$ 69.56	4.3%	$ 72.57	$ 80.99	1.0145	0.9991	0.9067	1.0045	0.9556	$ 71.45
08	Monroe	Family and Children	19-44 Years, Female	$ 229.60	0.9971	0.9987	0.9049	1.0335	0.9213	$ 196.99	4.3%	$ 205.45	$ 213.73	1.0172	0.9994	0.9028	1.0064	0.9471	$ 186.97
08	Monroe	Family and Children	19-44 Years, Male	$ 273.42	0.9971	0.9986	0.8786	1.0356	0.9281	$ 229.88	4.0%	$ 239.18	$ 227.37	1.0144	0.9994	0.8787	1.0060	0.9500	$ 193.58
08	Monroe	Family and Children	45+ Years, Female	$ 501.62	0.9968	0.9987	0.8551	1.0423	0.9308	$ 414.26	4.0%	$ 430.86	$ 470.92	1.0141	0.9993	0.8525	1.0073	0.9520	$ 390.13
08	Monroe	Family and Children	45+ Years, Male	$ 584.59	0.9988	0.9981	0.9015	1.0216	0.9219	$ 494.78	3.3%	$ 511.06	$ 461.38	1.0204	0.9992	0.8827	1.0096	0.9445	$ 396.01
08	Monroe	Foster Care Children	Foster Care, All Ages Male & Female	$ 140.49	0.9991	0.9992	0.8429	1.0194	0.9475	$ 114.17	4.2%	$ 118.95	$ 137.44	1.0209	0.9991	0.8524	1.0026	0.9666	$ 115.82
08	Monroe	Breast and Cervical Cancer	BCC, All Ages Female	$ 1,743.21	0.9988	0.9983	0.8709	1.1269	0.9213	$ 1,571.70	6.6%	$ 1,674.83	$ 1,501.71	1.0184	0.9996	0.8657	1.0031	0.9694	$ 1,286.87
08	Monroe	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 5,271.54	1.0000	1.0000	1.0000	1.0000	0.9157	$ 4,827.06	0.0%	$ 4,827.06	$ 5,436.69	1.0000	1.0000	1.0000	1.0000	0.9376	$ 5,097.23

Attachment B

CCN-S Benchmark PMPM Development

				5/1/2012-12/31/2012					
				Weighted FY09 and FY10 PMPM at FY10		Projected FFS PMPM	PMPM Post Smoothing w/Statewide		CCN-S Benchmark PMPM
DHH Administrative Region	Region Description	COA Description	RC Description	PMPM or Cost/Delivery	Trend	PMPM or Cost/Delivery	PMPM or Cost/Delivery	Catastrophic Limit Adjustment	PMPM or Cost/Delivery
05	Lake Charles	SSI	0-2 Months, Male and Female	$ 14,489.15	2.26%	$ 15,379.17	$ 18,171.42	0.9216	$ 16,747.48
05	Lake Charles	SSI	3-11 Months, Male and Female	$ 2,918.71	2.67%	$ 3,130.77	$ 3,934.18	0.9216	$ 3,625.88
05	Lake Charles	SSI	1-5 Years, Male and Female	$ 774.28	3.77%	$ 854.64	$ 698.10	0.9216	$ 643.39
05	Lake Charles	SSI	6-13 Years, Male and Female	$ 225.60	3.80%	$ 249.15	$ 221.06	0.9216	$ 203.74
05	Lake Charles	SSI	14-18 Years, Male and Female	$ 187.23	4.03%	$ 208.03	$ 234.98	0.9216	$ 216.57
05	Lake Charles	SSI	19-44 Years, Male and Female	$ 404.47	4.30%	$ 452.50	$ 452.50	0.9216	$ 417.03
05	Lake Charles	SSI	45+ Years, Male and Female	$ 715.38	4.11%	$ 796.60	$ 796.60	0.9216	$ 734.16
05	Lake Charles	Family and Children	0-2 Months, Male and Female	$ 1,291.78	2.24%	$ 1,370.22	$ 1,370.22	0.9551	$ 1,308.65
05	Lake Charles	Family and Children	3-11 Months, Male and Female	$ 248.63	3.34%	$ 271.36	$ 271.36	0.9551	$ 259.17
05	Lake Charles	Family and Children	1-5 Years, Male and Female	$ 107.83	3.90%	$ 119.42	$ 119.42	0.9551	$ 114.05
05	Lake Charles	Family and Children	6-13 Years, Male and Female	$ 69.08	4.06%	$ 76.81	$ 76.81	0.9551	$ 73.36
05	Lake Charles	Family and Children	14-18 Years, Female	$ 106.51	4.47%	$ 119.67	$ 119.67	0.9551	$ 114.29
05	Lake Charles	Family and Children	14-18 Years, Male	$ 71.24	4.51%	$ 80.12	$ 80.12	0.9551	$ 76.52
05	Lake Charles	Family and Children	19-44 Years, Female	$ 221.32	4.53%	$ 249.06	$ 249.06	0.9551	$ 237.87
05	Lake Charles	Family and Children	19-44 Years, Male	$ 200.43	4.51%	$ 225.46	$ 234.08	0.9551	$ 223.56
05	Lake Charles	Family and Children	45+ Years, Female	$ 372.15	3.91%	$ 412.25	$ 385.63	0.9551	$ 368.30
05	Lake Charles	Family and Children	45+ Years, Male	$ 466.63	4.13%	$ 519.87	$ 450.00	0.9551	$ 429.77
05	Lake Charles	Foster Care Children	Foster Care, All Ages Male & Female	$ 148.77	4.16%	$ 165.86	$ 143.90	0.9388	$ 135.09
05	Lake Charles	Breast and Cervical Cancer	BCC, All Ages Female	$ 1,738.09	8.12%	$ 2,140.22	$ 2,093.61	0.9085	$ 1,902.05
05	Lake Charles	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 4,394.07	0.00%	$ 4,394.07	$ 4,394.07	1.0000	$ 4,394.07
06	Alexandria	SSI	0-2 Months, Male and Female	$ 17,139.39	2.23%	$ 18,179.68	$ 18,171.42	0.9216	$ 16,747.48
06	Alexandria	SSI	3-11 Months, Male and Female	$ 4,011.60	2.33%	$ 4,265.53	$ 3,934.18	0.9216	$ 3,625.88
06	Alexandria	SSI	1-5 Years, Male and Female	$ 514.35	3.74%	$ 567.25	$ 698.10	0.9216	$ 643.39
06	Alexandria	SSI	6-13 Years, Male and Female	$ 224.07	3.66%	$ 246.59	$ 221.06	0.9216	$ 203.74
06	Alexandria	SSI	14-18 Years, Male and Female	$ 193.60	4.26%	$ 216.40	$ 234.98	0.9216	$ 216.57
06	Alexandria	SSI	19-44 Years, Male and Female	$ 370.53	4.23%	$ 413.83	$ 413.83	0.9216	$ 381.39
06	Alexandria	SSI	45+ Years, Male and Female	$ 713.37	3.88%	$ 789.51	$ 789.51	0.9216	$ 727.62
06	Alexandria	Family and Children	0-2 Months, Male and Female	$ 1,453.16	2.13%	$ 1,537.21	$ 1,537.21	0.9551	$ 1,468.14
06	Alexandria	Family and Children	3-11 Months, Male and Female	$ 231.93	3.49%	$ 254.13	$ 254.13	0.9551	$ 242.71
06	Alexandria	Family and Children	1-5 Years, Male and Female	$ 108.99	3.98%	$ 120.94	$ 120.94	0.9551	$ 115.51
06	Alexandria	Family and Children	6-13 Years, Male and Female	$ 69.68	4.13%	$ 77.61	$ 77.61	0.9551	$ 74.12
06	Alexandria	Family and Children	14-18 Years, Female	$ 108.07	4.57%	$ 121.73	$ 121.73	0.9551	$ 116.26
06	Alexandria	Family and Children	14-18 Years, Male	$ 73.28	4.52%	$ 82.45	$ 82.45	0.9551	$ 78.74
06	Alexandria	Family and Children	19-44 Years, Female	$ 210.53	4.52%	$ 236.86	$ 236.86	0.9551	$ 226.21
06	Alexandria	Family and Children	19-44 Years, Male	$ 216.17	4.43%	$ 242.69	$ 234.08	0.9551	$ 223.56
06	Alexandria	Family and Children	45+ Years, Female	$ 444.97	3.79%	$ 491.37	$ 385.63	0.9551	$ 368.30
06	Alexandria	Family and Children	45+ Years, Male	$ 535.74	3.59%	$ 588.61	$ 450.00	0.9551	$ 429.77
06	Alexandria	Foster Care Children	Foster Care, All Ages Male & Female	$ 116.10	4.19%	$ 129.53	$ 143.90	0.9388	$ 135.09
06	Alexandria	Breast and Cervical Cancer	BCC, All Ages Female	$ 1,880.01	6.74%	$ 2,237.19	$ 2,093.61	0.9085	$ 1,902.05
06	Alexandria	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 4,500.92	0.00%	$ 4,500.92	$ 4,500.92	1.0000	$ 4,500.92
07	Shreveport	SSI	0-2 Months, Male and Female	$ 13,286.49	2.24%	$ 14,093.39	$ 18,171.42	0.9216	$ 16,747.48
07	Shreveport	SSI	3-11 Months, Male and Female	$ 4,066.22	2.60%	$ 4,353.88	$ 3,934.18	0.9216	$ 3,625.88
07	Shreveport	SSI	1-5 Years, Male and Female	$ 439.69	3.71%	$ 484.59	$ 698.10	0.9216	$ 643.39
07	Shreveport	SSI	6-13 Years, Male and Female	$ 177.36	4.06%	$ 197.20	$ 221.06	0.9216	$ 203.74
07	Shreveport	SSI	14-18 Years, Male and Female	$ 269.75	3.67%	$ 296.99	$ 234.98	0.9216	$ 216.57
07	Shreveport	SSI	19-44 Years, Male and Female	$ 470.02	3.93%	$ 520.86	$ 520.86	0.9216	$ 480.03
07	Shreveport	SSI	45+ Years, Male and Female	$ 718.01	4.09%	$ 798.96	$ 798.96	0.9216	$ 736.34
07	Shreveport	Family and Children	0-2 Months, Male and Female	$ 1,440.32	2.10%	$ 1,522.39	$ 1,522.39	0.9551	$ 1,453.98
07	Shreveport	Family and Children	3-11 Months, Male and Female	$ 224.33	3.50%	$ 245.90	$ 245.90	0.9551	$ 234.85
07	Shreveport	Family and Children	1-5 Years, Male and Female	$ 94.31	4.08%	$ 104.93	$ 104.93	0.9551	$ 100.22
07	Shreveport	Family and Children	6-13 Years, Male and Female	$ 55.89	4.23%	$ 62.43	$ 62.43	0.9551	$ 59.62
07	Shreveport	Family and Children	14-18 Years, Female	$ 100.64	4.69%	$ 113.73	$ 113.73	0.9551	$ 108.62
07	Shreveport	Family and Children	14-18 Years, Male	$ 59.94	4.63%	$ 67.62	$ 67.62	0.9551	$ 64.58
07	Shreveport	Family and Children	19-44 Years, Female	$ 211.12	4.55%	$ 237.71	$ 237.71	0.9551	$ 227.03
07	Shreveport	Family and Children	19-44 Years, Male	$ 203.19	4.11%	$ 226.23	$ 234.08	0.9551	$ 223.56
07	Shreveport	Family and Children	45+ Years, Female	$ 348.90	4.17%	$ 389.07	$ 385.63	0.9551	$ 368.30
07	Shreveport	Family and Children	45+ Years, Male	$ 459.41	3.85%	$ 508.16	$ 450.00	0.9551	$ 429.77
07	Shreveport	Foster Care Children	Foster Care, All Ages Male & Female	$ 129.05	4.23%	$ 144.13	$ 143.90	0.9388	$ 135.09
07	Shreveport	Breast and Cervical Cancer	BCC, All Ages Female	$ 2,001.28	7.19%	$ 2,408.07	$ 2,093.61	0.9085	$ 1,902.05
07	Shreveport	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 4,833.32	0.00%	$ 4,833.32	$ 4,833.32	1.0000	$ 4,833.32

Attachment B

CCN-S Benchmark PMPM Development

				5/1/2012-12/31/2012					
				Weighted FY09 and FY10 PMPM at FY10		Projected FFS PMPM	PMPM Post Smoothing w/Statewide		CCN-S Benchmark PMPM
DHH Administrative Region	Region Description	COA Description	RC Description	PMPM or Cost/Delivery	Trend	PMPM or Cost/Delivery	PMPM or Cost/Delivery	Catastrophic Limit Adjustment	PMPM or Cost/Delivery
08	Monroe	SSI	0-2 Months, Male and Female	$ 16,692.64	2.23%	$ 17,704.25	$ 18,171.42	0.9216	$ 16,747.48
08	Monroe	SSI	3-11 Months, Male and Female	$ 2,538.77	3.01%	$ 2,747.78	$ 3,934.18	0.9216	$ 3,625.88
08	Monroe	SSI	1-5 Years, Male and Female	$ 807.00	3.47%	$ 883.95	$ 698.10	0.9216	$ 643.39
08	Monroe	SSI	6-13 Years, Male and Female	$ 229.30	3.76%	$ 253.03	$ 221.06	0.9216	$ 203.74
08	Monroe	SSI	14-18 Years, Male and Female	$ 209.22	4.06%	$ 232.67	$ 234.98	0.9216	$ 216.57
08	Monroe	SSI	19-44 Years, Male and Female	$ 425.15	3.84%	$ 470.04	$ 470.04	0.9216	$ 433.20
08	Monroe	SSI	45+ Years, Male and Female	$ 741.32	3.91%	$ 821.23	$ 821.23	0.9216	$ 756.86
08	Monroe	Family and Children	0-2 Months, Male and Female	$ 1,493.96	2.18%	$ 1,582.31	$ 1,582.31	0.9551	$ 1,511.22
08	Monroe	Family and Children	3-11 Months, Male and Female	$ 282.12	3.28%	$ 307.51	$ 307.51	0.9551	$ 293.69
08	Monroe	Family and Children	1-5 Years, Male and Female	$ 120.26	3.82%	$ 132.90	$ 132.90	0.9551	$ 126.93
08	Monroe	Family and Children	6-13 Years, Male and Female	$ 67.64	4.01%	$ 75.11	$ 75.11	0.9551	$ 71.73
08	Monroe	Family and Children	14-18 Years, Female	$ 107.20	4.34%	$ 120.04	$ 120.04	0.9551	$ 114.65
08	Monroe	Family and Children	14-18 Years, Male	$ 71.89	4.39%	$ 80.62	$ 80.62	0.9551	$ 77.00
08	Monroe	Family and Children	19-44 Years, Female	$ 194.36	4.35%	$ 217.72	$ 217.72	0.9551	$ 207.94
08	Monroe	Family and Children	19-44 Years, Male	$ 211.82	4.22%	$ 236.52	$ 234.08	0.9551	$ 223.56
08	Monroe	Family and Children	45+ Years, Female	$ 406.42	3.91%	$ 450.14	$ 385.63	0.9551	$ 368.30
08	Monroe	Family and Children	45+ Years, Male	$ 442.03	3.48%	$ 484.31	$ 450.00	0.9551	$ 429.77
08	Monroe	Foster Care Children	Foster Care, All Ages Male & Female	$ 117.07	4.29%	$ 130.95	$ 143.90	0.9388	$ 135.09
08	Monroe	Breast and Cervical Cancer	BCC, All Ages Female	$ 1,442.06	6.58%	$ 1,709.06	$ 2,093.61	0.9085	$ 1,902.05
08	Monroe	Maternity Kickpayment	Maternity Kickpayment, All Ages	$ 4,989.16	0.00%	$ 4,989.16	$ 4,989.16	1.0000	$ 4,989.16

Appendix G

Louisiana Medicaid State Plan Services

LOUISIANA STATE PLAN SERVICES					
Services	CMS Classification	Children Age 0 through Age 20	Pregnant*** Women	Adult Ages 21 & Older	Service Limits and/or Prior Authorization
Audiology Services	**Mandatory**	**√**	**√**	**N/A**	**√**
Early, Periodic Screening, Diagnostic and Treatment (EPSDT)	**Mandatory**	**√**	**√**	**N/A**	**√**
Family Planning	**Mandatory**	**√**	**√**	**√**	**√**
Federally Qualified Health Center	**Mandatory**	**√**	**√**	**√**	**√**
Home Health	**Mandatory**	**√**	**√**	**√**	**√**
Inpatient & Outpatient Hospital Services	**Mandatory**	**√**	**√**	**√**	**√**
Emergency Room Services	**Mandatory**	**√**	**√**	**√**	**√**
Lab & X-Ray	**Mandatory**	**√**	**√**	**√**	**√**
Medical and Surgical Dental Services	**Mandatory**	**√**	**√**	N/A	**√**
Nurse Midwife	**Mandatory**	**√**	**√**	**√**	**√**
Nursing Facility	**Mandatory**	**√**	**√**	**√**	**√**
Pediatric and Family Nurse Practitioner	**Mandatory**	**√**	**√**	**√**	**√**
Personal Care Services (EPSDT)	**Mandatory**	N/A	N/A	**√**	**√**
Physician Services	**Mandatory**	**√**	**√**	**√**	**√**
Pregnancy Related Services	**Mandatory**	**√**	**√**	**√**	**√**
Rural Health Clinic	**Mandatory**	**√**	**√**	**√**	**√**
Adult Denture	Optional	N/A	**√**	**√**	**√**
Adult Immunizations	Optional	**√**	**√**	**√**	**√**
Ambulatory Surgical Services	Optional	**√**	**√**	**√**	**√**
Behavioral / Mental Health (Non-EPSDT)	Optional	N/A	**√**	**√**	**√**
Chiropractic Services	Optional	**√**	N/A	N/A	**√**
Clinic Services*	Optional	**√**	**√**	**√**	**√**
Community Mental Health Services	Optional	**√**	**√**	**√**	**√**
Durable Medical Equipment - Appliances & Supplies	Optional	**√**	**√**	**√**	**√**
Emergency Dental Services	Optional	**√**	**√**	**√**	**√**
End Stage Renal Disease Services	Optional	**√**	**√**	**√**	**√**
Expanded Dental For Pregnant Women	Optional	N/A	**√**	N/A	**√**
Home Health Extended	Optional	**√**	N/A	N/A	**√**
Hospice	Optional	**√**	**√**	**√**	**√**
Inpatient Psychiatric Services for Children under 21 and Adults over 65	Optional	**√**	**√**	**√**	**√**
Laboratory and X-ray Services	Optional	**√**	**√**	**√**	**√**
Medical Transportation - Emergency	Optional	**√**	**√**	**√**	**√**
Medical Transportation - Non-Emergency	Optional	**√**	**√**	**√**	**√**
Optometrist (Non-EPSDT)	Optional	N/A	**√**	**√**	**√**
Organ Transplants	Optional	**√**	**√**	**√**	**√**
Orthodontia	Optional	**√**	N/A	N/A	**√**
Personal Care Services (LT-PCS)	Optional	N/A	**√**	N/A	**√**
Pharmacy	Optional	**√**	**√**	**√**	**√**

LOUISIANA STATE PLAN SERVICES					
Services	CMS Classification	Children Age 0 through Age 20	Pregnant*** Women	Adult Ages 21 & Older	Service Limits and/or Prior Authorization
Podiatry	Optional	√	√	√	√
Prosthetic & Orthotic Devices	Optional	√	√	√	√
Rehabilitative Services **	Optional	√	√	√	√
Targeted Case Management	Optional	√	√	√	√
Legend: √ = Covered Service / √ = Service has Limits and/or Requires Prior Authorization / Required N/A = Not Applicable					

*Including non-IEP Medicaid covered services provided in schools, and when such services are not funded through certified public expenditures.

** Excludes specifed early steps services.

***Shall provide pregnancy-related services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of being pregnant and includes but is not limited to prenatal care, delivery, postpartum care, and family planning service for pregnant women in accordance with 42 CFR Part 440 Subpart B

Appendix H - Louisiana Administrative Performance Measurement Set

Louisiana Administrative Performance Measurement Set

Measure	Minimal Performance Standard
* % of PCP Practices that provide verified 24/7 phone access with ability to speak with a PCP Practice clinician (MD, DO, NP, PA, RN, LPN) within 30 minutes of member contact.	≥95%
* % of regular and expedited service authorization request processed in timeframes in the contract	≥95%
* % of pre-processed claims that take more than two (2) business days to submit to the FI	≤ 5%
* Rejected claims returned to provider with reason code within 15 days of receipt of claims submission	≥99%
* % of Call Center calls answered by a live person within 30 seconds	≥90%
Call Center call average speed of answer	30 sec
Call Center call abandonment rate	≤ 5%
% of grievances received by the CCN including grievances received via telephone and resolved within the timeframe of the contract	≥95%

***Early Warning System Performance Measures**

Louisiana Performance Measurement Set for Adult/Pediatric Networks

Incentive Based Measures

ACCESS AND AVAILABILITY OF CARE	EFFECTIVENESS OF CARE		USE OF SERVICES
$$ Adults' Access to Preventive/ Ambulatory Health Services ** *HEDIS*	$$ Comprehensive Diabetes Care HgbA1C ***HEDIS*	$$ Chlamydia Screening in Women ***HEDIS/CHIPRA*	$$ Well-Child Visits in the Third, Fourth, Fifth and Sixth of Life ***HEDIS/CHIPRA*
			$$ Adolescent Well-Care Visits ***HEDIS/CHIPRA*

Louisiana Performance Measurement Set for Adult/Pediatric Networks

(Continued)

Level I Measures

ACCESS AND AVAILABILITY OF CARE	EFFECTIVENESS OF CARE		PREVENTION QUALITY INDICATORS	USE OF SERVICES
Children and Adolescents Access to PCP ** *HEDIS/CHIPRA*	Childhood Immunization Status ***HEDIS/CHIPRA*	Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents ***HEDIS/CHIPRA*	Adult Asthma Admission Rate ***AHRQ*	Well-Child Visits in the First 15 Months of Life ***HEDIS/CHIPRA*
Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care) ***HEDIS/CHIPRA*	Immunizations for Adolescents ***HEDIS/CHIPRA*	Use of Medication for people with Asthma ***HEDIS/CHIPRA*	CHF Admission Rate ***AHRQ*	Ambulatory Care (ER Utilization) ***HEDIS*
	Cholesterol Management for Patients with cardiovascular conditions ***HEDIS*	Comprehensive Diabetes Care ***HEDIS*	Uncontrolled Diabetes Admission Rate ***AHRQ*	
	Cervical CA Screening ***HEDIS*	Breast CA Screening ***HEDIS/CHIPRA*	Plan All-Cause Readmissions ** *HEDIS-Adapted for Medicaid*	
	EPSDT Screening Rate ***CMS 416*			

Louisiana Performance Measurement Set for Adult/Pediatric Networks

(Continued)

Level II Measures

Effectiveness of Care		Use of Services	Satisfaction and Outcomes
Follow-Up Care for Children Prescribed ADHD Medication ***HEDIS/CHIPRA*	Cesarean Rate for Low-Risk First Birth Women ***CHIPRA*	Emergency Utilization-Avg # of ED visits per member per reporting period ***CHIPRA*	CAHPS Health Plan Survey 4.0, Adult Version ***HEDIS*
Otitis Media Effusion ***CHIPRA*	Appropriate Testing for Children With Pharyngitis ***HEDIS/CHIPRA*	Annual # of asthma patients (1yr old) with 1 asthma related ER visit ***CHIPRA*	CAHPS Health Plan Survey 4.0, Child Version including Children With Chronic Conditions ***HEDIS/CHIPRA*
Controlling High Blood Pressure ***HEDIS*	% of Pregnant Women who are screened for tobacco usage and secondhand smoke exposure and are offered an appropriate and individualized intervention *** State*	Frequency of Ongoing Prenatal care ***HEDIS/CHIPRA*	Provider Satisfaction ***State*
Pediatric Central-Line Associated Bloodstream Infections ***CHIPRA*	Total number of eligible women who receive 17-OH progesterone during pregnancy, and % of preterm births at fewer than 37 weeks and fewer than 32 weeks in those recipients *** State*		
Percent of live births weighing less than 2,500 grams ***CHIPRA*			

Appendix I

WIC Referral Form

SAMPLE WIC REFERRAL FORM

PL103-448, §204(e) requires States using managed care arrangements to serve their Medicaid beneficiaries to coordinate their WIC and Medicaid Programs. This coordination should include the referral of potentially eligible women, infants, and children and the provision of medical information to the WIC Program. To help facilitate the information exchange process, please complete this form and send it to the address listed below. Thank you for your cooperation.

Name of Person Being Referred: _____

Address: _____

Telephone Number: _____

The following classifications describe the populations served by the WIC program. Please check the category that most appropriately describes the person being referred:

____ Pregnant woman

____ Woman who is breast-feeding her infant(s) up to one year postpartum

____ Woman who is not breast feeding up to six months postpartum

____ Infant (age 0-1)

____ Child under age 5

States may consider using this space to either include specific medical information or to indicate that such information can be provided if requested by the WIC Program.

I, the undersigned, give permission for my provider to give the WIC Program any required medical information.

_____

(Signature of the patient being referred or, in the case of children and infants, signature and printed name of the parent/guardian)

Send completed form to:

WIC Program Contact

Address

Phone Number

Appendix J

Rules Regarding Physician Incentive Plan

Rules Regarding Physician Incentive Plans

The CCN Physician Incentive Plan (herein referred to as Plan) must be approved by the State and any payments under the Plan must result in the provision of medically necessary care provided in accordance with the terms of the Contract with the Department and ensure:

(1) Services are offered in an amount, duration and scope that is no less than that furnished to beneficiaries under fee-for-service Medicaid;

(2) Services are offered in sufficient amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished;

(3) Providers under a Plan do not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition;

(4) Authorization of services is consistent with the DHH definition for medical necessity; and

(5) Plan is structured so as *not* to provide incentives for the provider to deny, limit or discontinue medically necessary services to any enrollee.

Appendix K

Provider's Bill Of Rights

PROVIDER'S BILL OF RIGHTS

Each CCN network provider who contracts with a CCN to furnish services to the members shall be assured of the following rights:

- A Health Care Professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a member who is his/her patient, for the following:
    - The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
    - Any information the member needs in order to decide among all relevant treatment options.
    - The risks, benefits, and consequences of treatment or non-treatment.
    - The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- To receive information on the Grievance, Appeal and State Fair Hearing procedures.
- To have access to the CCN's policies and procedures covering the authorization of services.
- To be notified of any decision by the CCN to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
- To appeal on behalf of a Medicaid/CHIP member to a state fair hearing a CCN action to deny, reduce or suspend medically necessary services.
- The CCN's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- To be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification.
- To dispute any issue or dispute that arises between a provider and a CCN that is not the result of a provider acting on behalf of an enrollee in the grievance and appeal process and is related to unique administrative functions of the CCN.

APPENDIX L

CCN Request for Member Disenrollment

CCN Request for Member Disenrollment

To: Medicaid CCN Enrollment Broker

From: _____

_____(CCN name) is requesting the member listed below to be disenrolled from for the following reason: _____

Print the Name of Member (Last, First, Middle Initial)	Birth Date	Medicaid ID Number or Social Security Number	Requested Disenrollment Date

☐ Member has demonstrated a pattern of disruptive, unruly, abusive or uncooperative behavior to the extent that enrollment in the CCN seriously impairs the organization's ability to furnish services to either the member or other members **and** the member's behavior is not caused by a physical or mental condition. (Attach separate narrative with additional information including measures taken by the CCN to correct the member's behavior prior to submitting the request for disenrollment)

☐ Member's utilization of services is fraudulent or abusive (e.g. member loans the CCN issued ID card to another person to obtain services). (Attach narrative with additional information including date of referral to Medicaid Program Integrity's Fraud Hotline)

☐ Member is placed in a long-term care nursing facility, ICF/DD facility, or becomes eligible for a Medicaid Home and Community-Based Services Waiver or hospice. Indicate which _____

☐ Member has died or is incarcerated. Date of death or incarceration _____

☐ Other _____

Signature: _____ Date: _____

The Louisiana Department of Health and Hospitals will determine if the CCN has shown a good cause to disenroll the Medicaid/CHIP member. The Enrollment Broker will give written notification to the CCN of the decision. Medicaid/CHIP members have the right to appeal disenrollment decisions and request a state fair hearing disenrollment to the Division of Administrative Law.

The CCN shall not discriminate against any Medicaid /CHIP member on the basis of their health status, need for health care services or any other adverse reason with regard to the member's health, race, sex, handicap, age, religion or national origin.

APPENDIX M

GUIDELINES FOR MEMBER DISENROLLMENT

GUIDELINES FOR MEMBER DISENROLLMENT

Generally the effective date of disenrollment from a CCN is prospective. Effective dates for other than routine disenrollments are described below.

Member Disenrollment *	
Reason for Disenrollment	**Disenrollment Effective Date**
Loss of Medicaid and CHIP eligibility	First day of month following Medicaid or CHIP case closure.
Death of member	First day of month following death. PMPM for months following the month of death will be recouped.
Intentional submission of fraudulent information	First day of month earliest month allowed by system.
Member moved outside of GSA	First day of month after the update of the system with the new address in different GSA.
Member moves out of state	First day of month after moving out state. Any PMPM payments for months following the month of the move will be recouped.
Member elects hospice	First day of the month following hospice election.
Member in LTC/NH	First day of the month following admission into NH.
Member elects Waiver Services	First day of the month following entry into waiver program.
Loss of CCN's participation	First day of month following CCN's termination date.
Member with more than one Medicaid Identification Number is enrolled in a CCN under more than one of the Medicaid Identification Numbers	First day of the month the duplicate enrollment began. Any duplicate PMPM payments will be recouped.
Incarceration	First day of the month following incarceration
Member enrolled in Medicare	First day of month following identification of Medicare coverage. Up to 12 retroactive months PMPM paid will be recouped.

Member Disenrollment *	
Reason for Disenrollment	**Effective Date of Disenrollment**
CCN request for disenrollment	First day of earliest month allowed by system edits following DHH approval.
Recipient on Inconsistent Parish Report	First day of earliest month allowed by system edits following verification of new address if new address is in a different GSA.
Member status changes to Section 1115 Medicaid Family Planning Waiver only	If the status of the member changes while in the hospital to a category where the hospital and physician charges would not be paid under FFS, the patient would be responsible for both the facility and physician charges for the uncovered portion of the stay (from the date that their status changes to FP services only).
Member terminates with one CCN and joins another while in hospital (disenrollment/ enrollment date occurs while in hospital)	The CCN that covers a member on the day of admission to a hospital will be responsible for the entire stay (facility charge), even if their CCN changes while they are inpatient. The date of service will dictate the responsible party for physician charges.

**DHH policy allows special exceptions to the disenrollment provisions listed above when in the best interest of the member and/or the Medicaid program. These exceptions will be considered on a case by case basis.*

***Inmate is defined as a person incarcerated in or otherwise confined to a correctional institution (i.e., jail). This does not include individuals on Probation or Parole or who are participating in a community program.*

Appendix N

Fiscal Intermediary Payment Schedule

Louisiana Department of Health and Hospitals
Medicaid CCN-S Payment Schedule

Year	Month	EFT Date	Expected Date of Deposit
2012	January	01/10/2012	01/11/2012
	February	02/14/2012	02/15/2012
	March	03/13/2012	03/14/2012
	April	04/10/2012	04/11/2012
	May	05/15/2012	05/16/2012
	June	06/12/2012	06/13/2012
	July	07/10/2012	07/11/2012
	August	08/14/2012	08/15/2012
	September	09/11/2012	09/12/2012
	October	10/09/2012	10/10/2012
	November	11/13/2012	11/14/2012
	December	12/11/2012	12/12/2012
2013	January	01/15/2013	01/16/2013
	February	02/12/2013	02/13/2013
	March	03/12/2013	03/13/2013
	April	04/09/2013	04/10/2013
	May	05/14/2013	05/15/2013
	June	06/11/2013	06/12/2013
	July	07/09/2013	07/10/2013
	August	08/13/2013	08/14/2013
	September	09/10/2013	09/11/2013
	October	10/15/2013	10/16/2013
	November	11/12/2013	11/13/2013
	December	12/10/2013	12/11/2013
2014	January	01/14/2014	01/15/2014
	February	02/11/2014	02/12/2014
	March	03/11/2014	03/12/2014
	April	04/15/2014	04/16/2014
	May	05/13/2014	05/14/2014
	June	06/10/2014	06/11/2014

Appendix O

DHH Marketing and Member Education Materials Approval Form

FOR DHH USE ONLY	
Submitted for *(choose one)*	Review ☐
	Approval ☐
Date Submitted by CCN	
Date of DHH Response *(see below for response)*	

DEPARTMENT OF HEALTH AND HOSPITALS
Medicaid

Louisiana Coordinated Care Network Program

Marketing and Member Education Materials Approval Form

COORDINATED CARE NETWORK CONTACT INFORMATION

CCN Name/ Name of Person Submitting/ Title:		
Address:		**GSA (s):**
Phone:	**E-mail:**	**Fax:**

MATERIAL DETAILS

Name of Material:

Type of Material (check one):

☐Print Ad ☐Radio Ad ☐TV Ad ☐Billboard ☐Flyer ☐Newsletter ☐News Release ☐Poster ☐Bus board ☐Website
☐Promotional Item ☐Phone Script ☐Brochure ☐Sign ☐Handbook ☐Directory ☐ Other: _____

Purpose or Goal of the Material: ☐Marketing ☐Member Education

DISTRIBUTION PLAN FOR MATERIAL

Target Audience for Material:
☐Members ☐Providers ☐General Public ☐Other: _____

Quantity or Impressions: *(number of materials to be printed/distributed or in the case of broadcast, the number of planned impressions)*

Distribution Plan for Material: *(should illustrate equitable distribution plan for the service area – attach additional pages as needed)*

Map or explanation of service area attached: ☐	**Media Buy Documentation Attached:** ☐

References to CCN Marketing and Member Education Plan: *(if not included in the most current Plan on file with DHH, a revised version of the Plan must be submitted as well)*

DHH RESPONSE

First Draft ☐ Make changes and return to DHH ☐ Approved with changes ☐ Approved for printing/publication	**First Draft** ☐ Make changes and return to DHH ☐ Approved with changes ☐ Approved for printing/publication	**First Draft** ☐ Make changes and return to DHH ☐ Approved with changes ☐ Approved for printing/publication
DHH Signature:	**DHH Signature:**	**DHH Signature:**
Date:	**Date**	**Date:**

Appendix P

DHH Event Submission Form

FOR DHH USE ONLY	
Date Submitted by CCN	
Date of DHH Response *(see below for response)*	

Louisiana Coordinated Care Network Program

Event Submission Form

COORDINATED CARE NETWORK CONTACT INFORMATION

CCN Name/ Name of Person Submitting/ Title:		
Address:		**GSA (s):**
Phone:	**E-mail:**	**Fax:**

EVENT HOST INFORMATION

Event Host Organization or Business:	**Event Host Contact:** *(Name and Title)*
Event Host Phone Number:	**Event Host E-mail:**

EVENT DETAILS

Name of Event:	**Date of Event:**	**Time of Event:**

Event Location: *(City, Parish and DHH Region, GSA)*	**Type of Event:** ☐Presentation ☐Community Event ☐Health Fair ☐Other: _____

Target Audience for Event:
☐Members ☐Providers ☐General Public ☐Other: _____

Brief Description of Event:

Materials to be Distributed at Event:

Marketing Event References to CCN Marketing Plan: *(if not included in the most current Marketing Plan on file with DHH, a revised version of the CCN Marketing Plan must be submitted as well)*

DHH RESPONSE

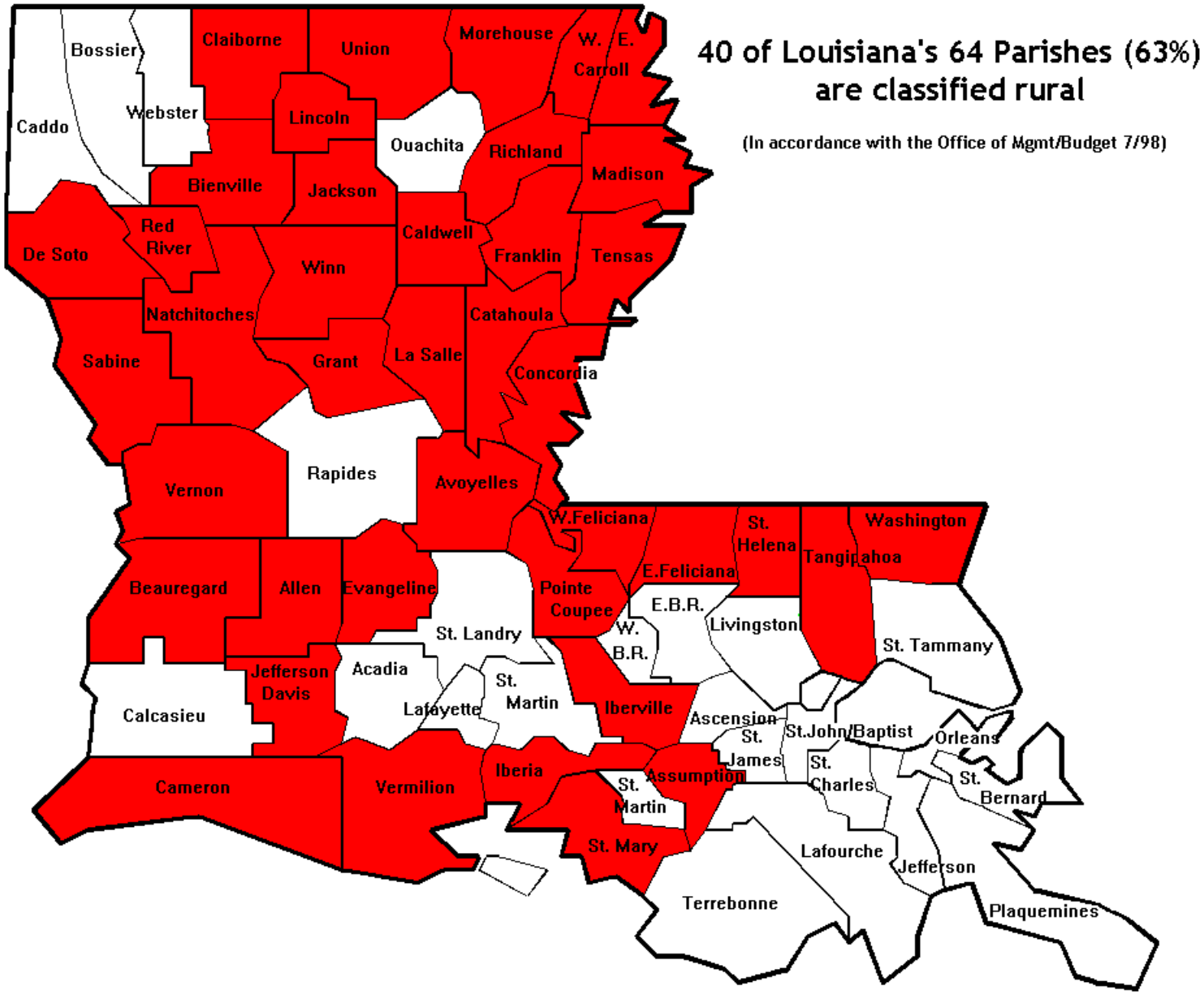
Approval Response: ☐ Event Approved ☐ Event Not Approved ☐ Further Detail Needed	**Additional Details Needed:**

DHH Signature:

Date:

Appendix Q

Map of Rural Parishes


40 of Louisiana's 64 Parishes (63%) are classified rural
(In accordance with the Office of Mgmt/Budget 7/98)
Bossier
Claiborne
Union
Morehouse
W.
E.
Carroll
Caddo
Webster
Lincoln
Ouachita
Richland
Madison
Bienville
Jackson
Red River
Caldwell
De Soto
Winn
Franklin
Tensas
Natchitoches
Catahoula
Sabine
Grant
La Salle
Concordia
Rapides
Vernon
Avoyelles
W.Feliciana
St. Helena
Washington
Tangipahoa
E.Feliciana
Beauregard
Allen
Evangeline
Pointe Coupee
E.B.R.
Livingston
St. Landry
W. B.R.
St. Tammany
Jefferson Davis
Acadia
St. Martin
Calcasieu
Lafayette
Iberville
Ascension
St. James
St.John/Baptist
Orleans
St. Charles
Cameron
Vermilion
Iberia
Assumption
St. Martin
St. Bernard
St. Mary
Lafourche
Jefferson
Terrebonne
Plaquemines

Appendix R

Marketing Complaint Form

FOR DHH USE ONLY	
STAGE OF REVIEW	DATE
☐ *Form Received at DHH*	
☐ *Investigation Begins*	
☐ *Sanctions Applied*	
☐ *Response Sent to Complainant*	
☐ *Investigation Closed*	

Louisiana Coordinated Care Network Program

Marketing Complaint Form

COMPLAINANT CONTACT INFORMATION

Complainant Name/ Title/Organization:

Address:

Phone:	**E-mail:**	**Fax:**

COMPLAINT DETAILS

Parties to the Alleged Violation: *(violator, witnesses and others)*

Date/Time/Frequency of Alleged Violation:

Location of Alleged Violation: *(facility name including location - address, unit, room, floor)*

Narrative/specifics of alleged violation: *(Please attach any documentation to support this allegation and attach additional pages if more space is needed for the narrative)*

Why is this alleged violation a violation of the Marketing Policy and Procedures? Please include citations to specific policies and procedures?

What harm has resulted due to this alleged violation? *(such as misrepresentation, unfair advantage gained)*

What is the complainant's expectation/desire for resolution/remedy, if any?

DHH INVESTIGATION NOTES

DHH Investigator Signature:
(at completion of investigation)

Print Name:	**Date:**

Appendix S

Member Bill of Rights

Louisiana Medicaid Coordinated Care Network Program

Member's and Potential Member's Bill of Rights

Each member and potential member is guaranteed the following rights:

- To be treated with respect and with due consideration for his/her dignity and privacy.
- To participate in decisions regarding his/her health care, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To be able to request and receive a copy of his/her medical records, (one copy free of charge) and request that they be amended or corrected.
- To receive health care services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- To receive all information — e.g., enrollment notices, informational materials, instructional materials, available treatment options and alternatives — in a manner and format that may be easily understood as defined in the Contract between DHH and the CCN.
- To receive assistance from both DHH and the Enrollment Broker in understanding the requirements and benefits of the CCN.
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To be notified that oral interpretation is available and how to access those services.
- As a potential member, to receive information about the basic features of the CCN program; which populations may or may not enroll in the program and the CCN's responsibilities for coordination of care in a timely manner in order to make an informed choice.
- To receive information on the CCN's services, to include, but not limited to:
    - Benefits covered
    - Procedures for obtaining benefits, including any authorization requirements
    - Any cost sharing requirements
    - Service area

  - Names, locations, telephone numbers of and non-English language spoken by current contracted providers, including at a minimum, primary care physicians, specialists, and hospitals
  - Any restrictions on member's freedom of choice among network providers
  - Providers not accepting new patients
  - Benefits not offered by the CCN but available to members and how to obtain those benefits, including how transportation is provided

- To receive a complete description of disenrollment rights at least annually.

- To receive notice of any significant changes in core benefits and services at least 30 days before the intended effective date of the change.

- To receive information on grievance, appeal and State Fair Hearing procedures.

- To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
  - What constitutes an emergency medical condition, emergency services, and post-stabilization services
  - That emergency services do not require prior authorization
  - The process and procedures for obtaining emergency services
  - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract
  - Member's right to use any hospital or other setting for emergency care
  - Post-stabilization care services rules as detailed in 42 CFR §422.113(c)

- To receive the CCN's policy on referrals for specialty care and other benefits not provided by the member's PCP.

- To have his/her privacy protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 Subparts A and E, to the extent that they are applicable.

- To exercise these rights without adversely affecting the way the CCN, its providers or DHH treat the member.

Appendix T

Marketing Plan Monthly Report

TO BE DETERMINED

APPENDIX U

GRIEVANCE AND STATE FAIR HEARING REPORT

20__ Coordinated Care Network Grievances and State Fair Hearing Reporting	
I. Contact Information	
Date:	
Coordinated Care Network Name:	
Contact Name:	
Contact Title:	
Address:	
Telephone Numbers:	
Local:	
Toll Free:	
E-mail Address:	
Name of IRO(s):	
(If CCN has more than 3 IROs, please attach a separate sheet.)	

_____ (CCN Name)

Grievances and State Fair Hearing Report

II. Review Activities

	Grievances	State Fair Hearings
Number of grievances reviewed:		
Number of grievances/State Fair Hearings resolved:		
*Percentage of overturned decisions:		
Number still pending at the end of 20__:		
Number of grievances considered ineligible:		
Average length of time to complete each grievances/State Fair Hearing process:		
Number of cases where CCN reversed its decision in the member's favor:		

* In cases where the decision was overturned in the member's favor, what was the most common reason? (e.g. availability of new information):

List the top 5 services that were most commonly the subject of grievances/State Fair Hearing (e.g. emergency room care, denial of service).
1
2
3
4
5

List the top 5 issues resulting in referral to an independent review organizations.
1
2
3
4
5

_____(CCN Name)

Grievances Summary Report

*Grievances received or completed in 20__ (If grievance was not completed in 20__, write "pending" in column 3.)

(1) Member ID	(2)* Date Grievance Was Received	(3)* Date Grievance Was Completed	(4) Days to Resolve	(5) Determination Upheld, Overturned, Partial	(6) Type of Service Denied (Be specific)	(7) Reason for Grievance (Use Number Code from Grievance Reason Summary)	(8) Explain Reason Grievance Was Upheld or Overturned	(9) Individual/Entity Requesting Review

_____(CCN Name)

State Fair Hearing

Annual Summary Report

*State Fair Hearings request received or completed in 20__ (If hearing was not completed in 20__, write "pending" in column 3.)

State Fair Heairng Reporting Period:

(1) Member ID	(2)* Date Request Was Received	(3)* Date Hearing Was Completed	(4) Days to Resolve	(5) Determination Upheld, Overturned, Partial	(6) Type of Service Denied (Be Specific)	(7) Reason For State Fair Hearing (Use Number Code from Appeal Reason Summary)	(8) Explain Reason State Fair Heairng Was Upheld or Overturned	(9) Individual/Entity Requesting Review

_____(CCN Name)

Grievances and State Fair Hearing Summary Chart

Denial Reason Number Code	Denial Reason	Number of Grievances	Number of State Fair Hearing Appeals
1	Left Blank Intentionally		
2	Clinical Criteria Not Met - Assistant Surgeon		
3	Clinical Criteria Not Met - Durable Medical Equipment		
4	Clinical Criteria Not Met - Inpatient Admissions		
5	Clinical Criteria Not Met - Medical Procedure		
6	Authorization		
7	Lack of Information from Provider		
8	Level of Care Dispute		
9	Not a State Plan Services		
10	Other		
TOTALS			

DO NOT ADD OR CHANGE REASON CODES

Appendix V

Performance Improvement Projects

Performance Improvement Projects

Performance Improvement Projects (PIPs)		
Section 1	**Minimum Threshold**	**Specifications**
Ambulatory Care Measure – ED Visit category - The number of ED visits per 1000 member months	2011 Medicaid NCQA Quality Compass at or below the 50thPercentile	HEDIS
Section 2	**Minimum Threshold**	**Specifications**
Cervical CA Screening - The percentage of women 24-64 years old in the denominator that received a cervical CA screening	2011 Medicaid NCQA Quality Compass at or above the 50thPercentile	HEDIS
Breast CA Screening – The percentage of women 40-69 years old that received a breast CA screening	2011 Medicaid NCQA Quality Compass at or above the 50thPercentile	HEDIS
Well Child Visits in the First 15 Months of Life – The percentage of children in the denominator that received at least 6 well child visits in the first 15 months of life	2011 Medicaid NCQA Quality Compass at our above the 50th Percentile	HEDIS
Childhood Immunization Status (CIS) The percentage of children two years of age who had the appropriate immunizations by their second birthday (Combination 2)	2011 Medicaid NCQA Quality Compass at our above the 50th Percentile	HEDIS
Elective Delivery Prior to 39 completed weeks gestation	Facility level	JCAHO
Cesarean Delivery Rate (nullipara)	Facility level	JCAHO
Elective Delivery	Facility level	JCAHO
Appropriate Use of Antenatal Steroids	Facility level	JCAHO
Exclusive Breastfeeding at Hospital Discharge	Facility level	JCAHO

APPENDIX W

Coordination of CCN Fraud and Abuse Complaints and Referrals

Louisiana Medicaid CCN Program
Coordination of CCN Fraud and Abuse Complaints and Referrals

The following set of policies and procedures has been developed to govern the disposition of fraud and abuse complaints along with the coordination of activities between DHH and Coordinated Care Networks (CCNs). Their purpose is to establish policy for coordination and referral of complaints made against healthcare providers providing services under a CCN and members enrolled in a CCN, in accordance with 42 CFR 455.

The Program Integrity Section and the Medicaid Coordinated Care Section will work jointly with the CCNs providing services to the Louisiana Medicaid and CHIP populations in order to ensure that all complaints for fraud and abuse are reviewed and investigated in a timely manner and that fraud referrals are made when appropriate. DHH receives fraud and abuse complaints via four main mechanisms:

- The Medicaid fraud hotline toll free number, 1-800-488-2917;
- U.S. mail, Program Integrity Section, P.O. Box 91030, Baton Rouge, LA 70821;
- Fraud reporting fax line 225-219-4155; or
- DHH's website www.dhh.louisiana.gov/offices/?ID=92 and click on the "Report Medicaid Fraud" button.

Coordination Involving Fraud and Abuse Complaints Received by DHH

- If DHH receives a complaint about a CCN member's **eligibility** for Medicaid/CHIP, the complaint is referred within three business days to the Medicaid Eligibility Field Operations Section.

- If DHH receives a complaint about a CCN member's **utilization of benefits**, the complaint is referred within three business days to the appropriate CCN.

- If DHH receives a complaint about a provider contracted with CCN(s), the complaint is referred to Program Integrity and Medicaid Coordinated Care Section for preliminary screening for fraud and abuse and/or referral to the appropriate CCN(s) for action.

Coordination for Fraud and Abuse Complaints Received by CCN

- If the CCN receives a complaint about a member's eligibility for Medicaid/CHIP, the complaint is referred to the Program Integrity Section. The referral is made within three business days.

- If the CCN receives a complaint about a member's utilization of benefits, the complaint is handled internally in accordance with the CCN's fraud and abuse/program integrity plan.

- If the CCN receives a complaint against a health care provider or contractor in its network, the CCN shall investigate in accordance with its fraud and abuse/ program integrity plan.

- The CCN will be required to capture data on complaints they receive and shall send reports to Program Integrity monthly.

Fraud and Abuse Referrals

- If a complaint or the findings of a preliminary investigation give the CCN reason to believe that fraud or abuse of the Medicaid program has occurred, the CCN must report this information to the Program Integrity Section within three (3) business days using one of the four mechanisms described above. Any suspicion or knowledge of fraud and abuse includes, but is not limited to, the false or fraudulent filings of claims and the acceptance or failure to return monies allowed or paid on claims known to be fraudulent, on the part of members, employees, providers, or contractors. The CCN should submit all relevant information about the case, including its findings and the details of its investigation through one of the four mechanisms DHH receives complaints.

- Upon suspicion of Medicaid fraud on the part of a member enrolled in a CCN, the CCN will refer the complaint to the Program Integrity Section within three (3) business days with all supporting evidence. .

- The Medicaid Coordinated Care Section will send a copy to Program Integrity of any fraud and abuse reports received from the CCNs within three (3) business days.

- For fraud cases against providers and members either initiated or referred by other Offices within DHH, the Office will inform the CCN and the Medicaid Coordinated Care Section when the case results in a criminal conviction, sanction, loss of benefits, and/or exclusion from the Medicaid program.

Excluded Providers

- The Program Integrity Section will update the Health Care Integrity and Protection Databank (HIPDB) to reflect all permissive and mandatory provider exclusions. The CCN shall be required to query the HIPDB for excluded providers. DHH will allow the CCN to become an authorized agent in order for the CCN to gain access to the HIPDB. Information concerning the data bank can be located at: http://www.npdb-hipdb.hrsa.gov/dpdb/

- CCNs shall also check the Excluded Parties List System (www.EPLS.gov) website and the Office of Inspector General Exclusion Database (http://exclusions.oig.hhs.gov/search.aspx) for excluded providers.

Information Sharing

The CCN's Compliance Offer will meet with the DHH Program Integrity Unit and Attorney General's Medicaid Fraud Control Unit (MFCU) on a quarterly basis to exchange information and collaboration on suspected fraud and abuse occurrences. These meetings may take place in person or via teleconference.

APPENDIX X

CCN-S Network Provider Subcontractor Listing Spreadsheet Requirements

CCN-S NETWORK PROVIDER SUBCONTRACTOR LISTING SPREADSHEET REQUIREMENTS

Please provide the following information regarding all Medicaid enrolled network providers:

1. **Practitioner Last Name, First Name and Title** - For types of service such as primary care providers and specialists, list the practitioner's name and practitioner title such as MD, NP (Nurse Practitioner), PA (Physician Assistant), etc.

2. **Practice Name/Provider Name** - Indicate the name of the provider. For practitioners indicate the professional association/group name, if applicable.

3. **Business Location Address** - Indicate the business location address where services are provided including but not limited to, 1st line of address, 2nd line of address, City, State, Postal Code and Telephone Numbers (office and fax).

4. **License Number** - Indicate the provider/practitioner license number, if appropriate.

5. **Medicaid Provider Number** – Indicate the provider/practitioner's Medicaid provider number, if they are a Medicaid provider.

6. **Provider Type and Specialty Code** - Indicate the practitioner's specialty using the attached Medicaid Provider Type and Specialty Codes.

7. **New Patient** - Indicate whether or not the provider is accepting new patients.

8. **Age Restriction** - Indicate any age restrictions for the provider's practice. For instance, if a physician only sees patients up to age 19, indicate < 19; if a physician only sees patients age 13 or above, indicate ≥ 13.

9. **Contract Name/Number** – Indicate which CCN subcontract the physician is associated with. Example: If the contract is for a group practice, all physicians within the group will have the same contract name/number.

10. **Contract Begin Date** – Indicate the date the contract became effective.

11. **Contract Termination Date** – Indicate the date the contract ended.

12. **Parish Served** – Indicate which parish or parishes the provider serves. Do so by listing all 64 parishes in alphabetical order (one column per parish) and placing an "X" in each appropriate column, indicating that the provider serves that parish. For example, if the provider has offices in 3 parishes, but is used by the CCN to provide services in 6 parishes, place an "X" in the columns of each of the 6 parishes served.

On separate tabs to the spreadsheet, please provide listings of all 1) new and 2) terminated providers for the month. For these tabs, please provide the information requested in items 1-12 above.

Appendix Y

CCN Disenrollment Report

CCN Disenrollment Report

TO BE DETERMINED

APPENDIX Z

CCN Model Attestation Letter for Reports

Model Attestation Letter for Reports

(Company Letter Head)

Attestation for Reports

Date_____

I, _____, as (Title) for (Name of Company), do hereby attest, based upon my best knowledge, information and belief, that the data provided in the _____ Report(s) is accurate, true, and complete.

I understand that should DHH determine the submitted information is inaccurate, untrue, or incomplete, (Name of company) may be subject to monetary penalties or sanctions and/or fines as outlined in SECTION 18 of the Contract.

_____ _____

Signature/Title Date

Appendix AA

Transition Period Requirements

Appendix AA

Transition Period Requirements

Introduction

This Section presents the scope of work for the Transition period of the Contract, which includes those activities that must take place between the time of Contract award and the Go Live Date.

Each CCNs Go Live Date will be determined by DHH once requirements are met.

The Transition Period will include a Readiness Review of each CCN, which must be completed successfully prior to a CCN's Go Live Date. DHH may, at its discretion, postpone the Operation Start Date of the Contract for any such CCN that fails to satisfy all Transition Period requirements.

Transition Period Requirements

CCNs must have successfully met all Readiness Review requirements established by DHH no later than 90 days prior to the Go Live Date. The CCN agrees to provide all materials required to complete the readiness review by the dates established by DHH and/or its Readiness Review contractor.

If a CCN does not fully meet the Readiness Review prior to the Go Live Date, DHH may impose a monetary penalty for each day beyond the Go Live Date that the CCN is not operational.

The Transition Period will begin after both Parties sign the Contract. The start date for the CCN Transition Period is anticipated to be on or after September, 2011. .

The CCN has overall responsibility for the timely and successful completion of each of the Transition Period tasks. The CCN is responsible for clearly specifying and requesting information needed from DHH, other DHH contractors, and Providers in a manner that does not delay the schedule of work to be performed.

1. **Contract Start-Up and Planning**

   DHH and the CCN will work together during the initial Contract start-up phase:

   - define project management and reporting schedules;
   - establish communication protocols between DHH and the CCN;
   - establish contacts with DHH contractors;
   - establish a schedule for key activities and milestones; and
   - clarify expectations for the content and format of Contract Deliverables.

   The CCN will be responsible for developing a written work plan, referred to as the Transition/Implementation Plan, which will be used to monitor progress throughout the Transition Period. An updated and detailed Transition/Implementation Plan will be due to DHH within thirty (30) days from the date the contract is signed by the CCN.

2. **Administration and Key CCN Personnel**

No later than August 1, 2011, the CCN must designate and identify Key CCN Personnel that meet the requirements of the contract. The CCN will supply DHH with resumes of each Key CCN Personnel as well as organizational information that has changed relative to the CCN Proposal, such as updated job descriptions and updated organization charts, (including updated Management Information System (MIS) job descriptions and an updated MIS staff organizational chart), if applicable. If the CCN is using a Subcontractor(s), the CCN must also provide the organization chart for such Subcontractor(s).

No later than the Contract execution date, CCNs must update the information above and provide any additional information as it relates to the Coordinated Care Network Program.

3. **Financial Readiness Review**

In order to complete a Financial Readiness Review, DHH will require that CCNs update information submitted in their proposal and or any other requirements specified in the RFPs. This information will include the following and the requirements specified in the Proposal Submission and Evaluation Requirements.

Contractor Identification and Information

1. The Contractor's legal name, trade name, or any other name under which the Contractor does business, if any.

2. The address and telephone number of the Contractor's headquarters office.

3. A copy of its current Louisiana Department of Insurance Certificate of Authority to provide HMO services.

4. The type of ownership (proprietary, partnership, corporation).

5. The type of incorporation (for profit, not-for-profit, or non-profit) and whether the CCN is publicly or privately owned.

6. If the CCN is an Affiliate or Subsidiary, identify the parent organization.

7. If any changes of ownership of the CCN's company is anticipated during the 12 months following the Proposal due date, the CCN must describe the circumstances of such change and indicate when the change is likely to occur.

8. The name and address of type of support, e.g. guarantees, letters of credit, etc. Indicate if there are maximum limits of the additional financial support.

9. The name and address of any health professional that has at least a five percent financial interest in the CCN and the type of financial interest.

10. The names of officers and directors.

11. The state in which the CCN is incorporated and the state(s) in which the CCN is licensed to do business as an HMO. The CCN must also indicate the state where it is commercially domiciled, if applicable.

12. The CCN's federal taxpayer identification number.

13. Whether the CCN had a contract terminated or not renewed for non-performance or poor performance within the past five years. In such instance, the CCN must describe the issues and the parties involved, and provide the address and telephone of the principal terminating party. The CCN must also describe any corrective action taken to prevent any future occurrence of the problem leading to the termination.

14. Whether the CCN has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status, and if it has or is, indicate:
    - is current NCQA or URAC accreditation status;
    - if NCQA or URAC accredited, its accreditation term effective dates; and
    - if not accredited, a statement describing whether and when NCQA or URAC accreditation status was ever denied the CCN.

Subcontractor Information

CCN's must submit the following for each proposed Subcontractor, if any:

1. A completed attestation of commitment from each Subcontractor that states the Subcontractor's willingness to enter into a Subcontractor agreement with the CCN and a statement of work for activities to be subcontracted. Attestations must be provided on the Subcontractor's official company letterhead and signed by an official with the authority to bind the company for the subcontracted work.

2. The Subcontractor's legal name, trade name, or any other name under which the Subcontractor does business, if any.

3. The address and telephone number of the Subcontractor's headquarters office

4. The type of ownership (e.g., proprietary, partnership, corporation).

5. The type of incorporation (i.e. for profit, not-for-profit, or non-profit) and whether the Subcontractor is publicly or privately owned.

6. If a Subsidiary or Affiliate, the identification of the parent organization.

7. The name and address of any sponsoring corporation or others who provide financial support to the Subcontractor and type of support, e.g., guarantees, letters of credit, etc. Indicate if there are maximum limits of the additional financial support.

8. The name and address of any health professional that has at least a five percent (5%) financial interest in the Subcontractor and the type of financial interest.

9. The state in which the Subcontractor is incorporated, commercially domiciled, and the state(s) in which the organization is licensed to do business.

10. The Subcontractor's federal taxpayer identification number.

11. Whether the CCN had a contract terminated or not renewed for non-performance or poor performance within the past five years. In such instance, the CCN must describe the issues and the parties involved, and provide the address and telephone of the principal terminating party. The CCN must also describe any corrective action taken to prevent any future occurrence of the problem leading to the termination.

12. Whether the CCN has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status, and if it has or is, indicate:
    a. is current NCQA or URAC accreditation status;
    b. if NCQA or URAC accredited, its accreditation term effective dates; and
    c. if not accredited, a statement describing whether and when NCQA or URAC accreditation status was ever denied the CCN.

Other Information

1. Briefly describe any regulatory action, sanctions, and/or fines imposed by any federal or Louisiana regulatory entity or a regulatory entity in another state within the last three (3) years, including a description of any letters of deficiencies, corrective actions, findings of non-compliance, and/or sanctions. Please indicate which of these actions or fines, if any, were related to Medicaid or CHIP programs. DHH may, at its option, contact these clients or regulatory agencies and any other individual or organization whether or not identified by the CCN.

2. No later than thirty (30) days after the Contract Effective Date, submit documentation that demonstrates that the CCN has secured the required insurance and bonds in accordance with DHH requirements.

3. Submit annual audited financial statement for fiscal years 2010 and 2011 (2011 to be submitted no later than six months after the close of the fiscal year).

4. Submit an Affiliate Report containing a list of all Affiliates and for DHH's prior review and approval, a schedule of all transactions with Affiliates that, under the

provisions of the Contract, will be allowable as expenses in the Financial Report for services provided to the CCN by the Affiliate. Those should include financial terms, a detailed description of the services to provided, and an estimated amount that will be incurred by the CCN for such services during the Contract Period.

System Testing and Transfer of Data

The CCN must have hardware, software, network and communications systems with the capability and capacity to handle and operate all MIS systems and subsystems.

During the Readiness Review task, the CCN will accept into its system any and all necessary data files and information available from DHH or its contractors. The CCN will install and test all hardware, software, and telecommunications required to support the Contract. The CCN will define and test modifications to the CCN's system(s) required to support the business functions of the Contract.

The CCN will produce data extracts and receive data transfers and transmissions. CCNs must be able to demonstrate the ability to produce encounter file.

If any errors or deficiencies are evident, the CCN will develop resolution procedures to address the problem identified. The CCN will provide DHH, or designated contractor, with test data files for systems and interface testing for all external interfaces. This includes testing of the required telephone lines for Providers and Members and any necessary connections to the Enrollment Broker and External Quality Review Organization. The CCN will demonstrate its system capabilities and adherence to Contract specifications during readiness review.

System Readiness Review

The CCN must assure that system services are not disrupted or interrupted during the Operations Phase of the Contract, as defined in the Information Systems Availability section of the RFP. The CCN must coordinate with DHH and other contractors to ensure the business and systems continuity for the processing of all health care claims and data as required under this Contract.

The CCN must submit to DHH, descriptions of interface and data and process flow for each business processes described in the ***CCN-P Systems Companion Guide.***

The CCN must clearly define and document the policies and procedures that will be followed to support day-to-day systems activities. The CCN must develop, and submit for DHH review and approval, the following information no later than 30 days after the Contract is signed:

1. Disaster Recovery Plan
2. Business Continuity Plan
3. Systems Quality Assurance Plan

Demonstration and Assessment of System Readiness

The CCN must provide documentation on systems and facility security and provide evidence or demonstrate that it is compliant with HIPAA, as specified in the Information Security and Access Management section and as otherwise stated in the RFP. The CCN shall also provide DHH with a summary of all recent external audit reports, including findings and corrective actions, relating to the CCN's proposed systems. The CCN shall promptly make additional information on the detail of such system audits available to DHH upon request.

In addition, DHH will provide to the CCN a test plan that will outline the activities that need to be performed by the CCN prior to the Go Live Date of the Contract, as outlined in the CCN-P Systems Companion Guide. The CCN must be prepared to assure and demonstrate system readiness. The CCN must execute system readiness test cycles to include all external data interfaces, including those with Subcontractors.

DHH, or its contractors, may independently test whether the CCN's MIS has the capacity to administer a Coordinated Care Network. This Readiness Review of a CCN's MIS may include a desk review and/or an onsite review. Based in part on the CCN's assurances of systems readiness, information contained in the Proposal, additional documentation submitted by the CCN, and any review conducted by DHH or its contractors, DHH will assess the CCN's understanding of its responsibilities and the CCN's capability to assume the MIS functions required under the contract.

The CCN is required to provide a Corrective Action Plan in response to any Readiness Review deficiency no later than ten (10) calendar days after notification of any such deficiency by DHH. If the CCN documents to DHH's satisfaction that the deficiency has been corrected within ten (10) calendar days of such deficiency notification by DHH, no Corrective Action Plan is required.

Operation Readiness

The CCN must clearly define and document the policies and procedures that will be followed to support day-to-day business activities related to Louisiana Medicaid enrollees, including coordination with contractors. The CCN will be responsible for developing and documenting its approach to quality assurance.

Readiness Review includes all plans to be implemented in one Geographic Service Area (GSA) on the anticipated Operational Start Date. At a minimum, the CCN shall:

1. Develop operations procedures and associated documentation to support the CCN's proposed approach to conducting operations activities in compliance with the contracted scope of work.

2. Submit to DHH, a listing of all contracted and credentialed Providers, in a DHH approved format including a description of additional contracting and credentialing activities scheduled to be completed before the Go Live Date.

3. Prepare and implement a Member Services staff training curriculum and a Provider training curriculum.

4. Prepare a Coordination Plan documenting how the CCN will coordinate its business activities with those activities performed by DHH contractors and the CCN's Subcontractors, if any. The Coordination Plan will include identification of coordinated activities and protocols for the Transition Period.

5. Develop and submit to DHH the draft Member Handbook, draft Provider Manual, draft Provider Directory, and draft Member Identification Card for DHH's review and approval. The material must at a minimum meet the requirements specified in the Request for Proposal.

6. Develop and submit to DHH the CCN's proposed Member complaint and appeals processes.

7. Provide sufficient copies of final Provider Directory to the DHH's Enrollment Broker in sufficient time to meet the enrollment schedule.

8. Demonstrate toll-free telephone systems and reporting capabilities for the Member Services Hotline and Provider Service Hotline.

9. Submit a written Fraud and Abuse Compliance Plan to DHH for approval no later than 30 days from the date the Contract is signed. As part of the Fraud and Abuse Compliance Plan as described in this RFP , the CCN shall:

    - Designate a compliance officer and essential personnel to attend mandatory training in fraud and abuse detection, prevention and reporting. Executive and essential fraud and abuse personnel means CCN staff persons who supervise staff in the following areas: data collection, provider enrollment or disenrollment, encounter data, claims processing, utilization review, appeals or grievances, quality assurance and marketing, and who are directly involved in the decision-making and administration of the fraud and abuse detection program within the CCN.

    - Designate an officer within the organization responsible for carrying out the provisions of the Fraud and Abuse Compliance Plan.

    - The CCN is held to the same requirement and must ensure that, if this function is subcontracted to another entity, the subcontractor also meets all the requirements.

During the Readiness Review, DHH may request from the CCN certain operating procedures and updates to documentation to Coordinated Care Network Services. DHH will assess the CCN's understanding of its responsibilities and the CCN's capability to assume the functions required under the Contract, based in part on the

CCN's assurances of operational readiness, information contained in the Proposal, and in Transition Period documentation submitted by the CCN.

The CCN is required to promptly provide a Corrective Action Plan as requested by DHH in response to Operational Readiness Review deficiencies identified by the CCN or by DHH's contractors. The CCN must promptly alert DHH of deficiencies, and must correct a deficiency or provide a Corrective Action Plan no later than ten (10) calendar days after DHH's notification of deficiencies. If the CCN documents to DHH's satisfaction that the deficiency has been corrected within ten (10) calendar days of such deficiency notification by DHH, no Corrective Action Plan is required.

Assurance of System and Operation Readiness

In addition to successfully providing the Deliverables described in the RFP, the CCN must assure DHH that all processes, MIS systems, and staffed functions are ready and able to successfully assume responsibilities for operations prior to the Go Live Date. In particular, the CCN must assure that Key CCN Personnel, Member Services staff, Provider Services staff, and MIS staff are hired and trained, MIS systems and interfaces are in place and functioning properly, communications procedures are in place, Provider Manuals have been distributed, and that Provider training sessions have occurred according to the schedule approved by DHH.

Post-Transition

The CCN will work with DHH, Providers, and Members to promptly identify and resolve problems identified after the Go Live Date and to communicate to DHH, Providers, and Members, as applicable, the steps the CCN is taking to resolve the problems.

If a CCN makes assurances to DHH of its readiness to meet Contract requirements, including MIS and operational requirements, but fails to satisfy requirements set forth in this Section, or as otherwise required pursuant to the Contract, DHH may, at its discretion do any of the following in accordance with the severity of the non-compliance and the potential impact on Members and Providers:

1. freeze enrollment into the CCN's plan for the affected GSA;
2. freeze enrollment into the CCN's plan for all affected GSAs
3. impose contractual monetary penalties, or
4. pursue other equitable, injunctive, or regulatory relief.

Appendix BB

Proposal and Evaluation Guide

APPENDIX BB

LOUISIANA COORDINATED CARE NETWORK PROGRAM

CCN-S PROPOSAL SUBMISSION AND EVALUATION REQUIREMENTS

RFP # 305PUR-DHHRFP-CCN-S MVA

CCN-S POINTS SUMMARY

PART I – MANDATORY – Total Possible Points - 0

Section	Category	Total Possible Points
A	Mandatory Requirements	0

PART II – Technical - Total Possible Points – 1,650

Section	Category	Total Possible Points
B	Qualifications and Experience	340
C	Planned Approach to Project	100
D	Member Enrollment and Disenrollment	25
E	Chronic Care/Disease Management	100
F	Service Coordination	160
G	Provider Network	110
H	Utilization Management	80
I	EPSDT	25
J	Quality Management	115
K	Member Materials	50
L	Customer Service	100
M	Emergency Management Plan	25
N	Grievance and Appeals	25
O	Fraud and Abuse	15
P	Claims Management	80
Q	Information Systems	200
R	Added Value to Louisiana	100
	TOTAL	**1,650**

LOUISIANA COORDINATED CARE NETWORK PROGRAM CCN-S PROPOSAL SUBMISSION AND EVALUATION REQUIREMENTS RFP # 305PUR-DHHRFP-CCN-S MVA	
PROPOSER NAME	

THE PROPOSER MUST COMPLETE THIS FORM AND SUBMIT WITH THEIR PROPOSAL.

PART ONE: MANDATORY REQUIREMENTS

The Proposer should address ALL Mandatory Requirements section items and should provide, in sequence, the information and documentation as required (referenced with the associated item references).

The DHH Division of Contracts and Procurement Support will review all general mandatory requirements.

The DHH Division of Contracts and Procurement Support will also review the proposal to determine if the Mandatory Requirement Items (below) are met and mark each with included or not included.

Any contract resulting from this RFP process shall incorporate by reference the respective proposal responses to all items below as a part of said contract (refer to Section 20 of RFP).

The proposer should adhere to the specification outlined in Section 20 of the RFP in responding to this RFP. The Proposer should complete all columns marked in ORANGE ONLY.

NOTICE: In addition to these requirements, DHH will also evaluate compliance with ALL other RFP provisions.

Proposal Section and Page Number	Specify Applicable GSA Area (A,B and/or C)	PART ONE: MANDATORY REQUIREMENT ITEMS	For State Use Only	
			INCLUDED/NOT INCLUDED	DHH COMMENTS
		A.1 Provide the Proposal Transmittal Statement (RFP Appendix A) completed and signed, in the space provided, by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract. ***The Proposer must sign the Proposal Transmittal Statement without exception or qualification.***		
		A.2 Provide a statement signed by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract containing a guarantees that there will be no conflict or violation of the Ethics Code if the proposer is awarded a contract. Ethics issues are interpreted by the Louisiana Board of Ethics.		

PART II: TECHNICAL PROPOSAL & EVALUATION GUIDE

The proposer should adhere to the specification outlined in Section 20 of the RFP in responding to this RFP. The Proposer should address ALL section items and provide, in sequence, the information and documentation as required (referenced with the associated item references and text and complete all columns marked in ORANGE ONLY.

***If Proposer is proposing to provide services in all GSAs, you may respond by stating "all" in the Specify Applicable GSA Area column. If not, you must specify the specific GSA.**

Proposal Evaluation Teams, made up of teams with three or more State employees, will evaluate and score the proposal's responses.

For those items in Part II that state in the Total Possible Points column "Included/Not Included"; the proposals will be scored as follows:

a. **All items scored Included = 0 points**
b. **If 1-3 items are scored "Not Included" = -10 points**
c. **If 4-5 items are scored "Not Included" = -20 points**
d. **If more than 6 items are scored "Not Included" = -30 points**

Any contract resulting from this RFP process shall incorporate by reference the respective proposal responses to all items below as a part of said contract.

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	For Sate Use Only	
				Score	DHH Comments
		B. Qualifications and Experience (Section 3-5 of the RFP)	**340**		
		B.1 Indicate your organization's legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g. publicly traded corporation). Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest. Indicate the name, title, mailing address and phone number(s) of the person DHH should contact regarding the Proposal. Provide your federal taxpayer identification number and Louisiana taxpayer identification number. Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provider the name and address of the local representative; if none, so state. If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.	**Included/Not Included**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. I**nclude your organization's parent organization, affiliates, and subsidiaries.**	**Included/Not Included**		
		B.3 Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have **ever** been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. **Include your organization's parent organization, affiliates, and subsidiaries**.	**0 to -25**		
		B.4 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. I**nclude your organization's parent organization, affiliates, and subsidiaries.**	**0 to -25**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		B.5 Provide a statement of whether, in the last ten years, you 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, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. I**nclude your organization's parent organization, affiliates, and subsidiaries.**	**0 to -25**		
		B.6 If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report. Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. I**nclude your organization's parent organization, affiliates, and subsidiaries.**	**0 to -25**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		B.7 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner. Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.	**Included/Not Included**		
		B.8 Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. **Include your organization's parent organization, affiliates, and subsidiaries.**	**Included/Not Included**		
		B.9 Provide a narrative description of your proposed project team, its members, and organizational structure including an organizational chart showing the Louisiana organizational structure, including staffing and functions performed at the local level. If proposing for more than one (1) GSA, include in your description and organizational chart if: 1) the team will be responsible for all GSAs or 2) each GSA will differ provide details outlining the differences and how it will differ.	**15**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		B.10 Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience. If any of personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number. If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages. For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.	**40**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		B.11 Provide a statement of whether you intend to use major subcontractors (as defined in the Glossary), and if so, the names and mailing addresses of the major subcontractors and a description of the scope and portions of the work for each subcontractor with more than $100,000 annually. Describe how you intend to monitor and evaluate subcontractor performance. Also specify whether the subcontractor is currently providing services for you in other states and where the subcontractor is located. In addition, as part of the response to this item for each major subcontractor that is not your organization's parent organization affiliate, or subsidiary, restate and respond to items B.1 through B.7, B.10, B.16 through B.27. If the major subcontractor is your organization's parent organization, affiliate, or subsidiary, respond only to items B.1, B.8 and B.9; you do not need to respond to the other items as part of the response to B.11; note, however, responses to various other items in Section B must include information on your organization's parent organization, affiliates, and subsidiaries, which would include any major subcontractors that are your organization's parent organization, affiliate, or subsidiary.	**10**		
		B.12 Provide a description your Corporate Compliance Program including the Compliance Officer's levels of authority and reporting relationships. Include an organizational chart of staff (marked as Chart B in your response) involved in compliance along with staff levels of authority.	**15**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		B.13 Provide copies of any press releases in the twelve (12) months prior to the Deadline for Proposals, wherein the press release mentions or discusses financial results, acquisitions, divestitures, new facilities, closures, layoffs, significant contract awards or losses, penalties/fines/ sanctions, expansion, new or departing officers or directors, litigation, change of ownership, or other very similar issues, Do not include press releases that are primarily promotional in nature.	**10**		
		B.14 Describe your plan for meeting the Performance Bond, other bonds, and insurance requirements set forth in this RFP requirement including the type of bond to be posted and source of funding.	**Included/Not Included**		
		B.15 Provide the following information (in Excel format) based on each of the financial statements provided in response to item B.26: (1) Working capital; (2) Current ratio; (3) Quick ratio; (4) Net worth; and (5) Debt-to-worth ratio.	**20**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		B.16 Identify, in Excel format, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. I**nclude your organization's parent organization, affiliates, and subsidiaries.** **If no publicly funded Medicaid/CHIP contracts, so state.**	**75**		
		B.17 Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. **Include your organization's parent organization, affiliates, and subsidiaries.**	**Included/Not Included**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		B.18 If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. **Include your organization's parent organization, affiliates, and subsidiaries.**	**0 to -25**		
		B. 19 As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following: • AM Best Company (financial strengths ratings); • TheStreet.com, Inc. (safety ratings); and • Standard & Poor's (long-term insurer financial strength.	**0 to -25**		
		B.20 For any of your organization's contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (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 Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? **Include your organization's parent organization, affiliates, and subsidiaries.**	**0 to -25**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		B.21 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act or other review administrative/clinical analysis conducted by the State) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (**including your organization's parent organization, affiliates, and subsidiaries**) in response to the report. If not applicable, so state.	**25**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		B.22 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. I**nclude your organization's parent organization, affiliates, and subsidiaries.**	**0 to -50**		
		B.23 Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. **Include your organization's parent company, affiliates and subsidiaries.**	**0 to -25**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		B.24 Submit client references (minimum of three, maximum of five) for your organization from major subcontractor; with at least one reference from a major subcontractor who have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix GG. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps: a. Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix GG (for your organization or for subcontractors, adding the following customized information: • Your/Subcontractor's name; • Geographic Service Area(s) for which the reference is being submitted; • Reference organization's name; and • Reference contact's name, title, telephone number, and email address. b. Send the form to each reference contact along with a new, sealable standard #10 envelope; c. Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal; d. Instruct the reference contact to: • Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission); • Sign and date it; • Seal it in the provided envelope; • Sign the back of the envelope across the seal; and	**30**		

		• Return it directly to you. e. Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references. **THE STATE WILL NOT ACCEPT LATE REFERENCES OR REFERENCES SUBMITTED THROUGH ANY OTHER CHANNEL OF SUBMISSION OR MEDIUM, WHETHER WRITTEN, ELECTRONIC, VERBAL, OR OTHERWISE.** Each completed questionnaire should include: • Proposing Organization/Subcontractor's name; • GSA (s) for which the reference is being submitted; • Reference Organization's name; • Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work; • Date reference form was completed; and • Responses to numbered items in RFP Attachment # (as applicable). DHH reserves the authority to clarify information presented in questionnaires and may consider clarifications in the evaluation of references. However DHH is under no obligation to clarify any reference check information.			
		B.25 Indicate the website address (URL) for the homepage(s) of any website(s) operated, owned, or controlled by your organization, including any that the Proposer has contracted to be run by another entity as well as details of any social media presence (*e.g.* Facebook, Twitter). If your organization has a parent, then also provide the same for the parent, and any parent(s) of the parent. If no websites and/or social media presence, so state.	**Included/Not Included**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		B.26 Provide the following as documentation of financial responsibility and stability: • a current written bank references, in the form of a letter, indicating that the Proposer's business relationship with the financial institution is in positive standing; • two current written, positive credit references, in the form of standard business letters, from vendors with which the Proposer has done business or, documentation of a positive credit rating determined by a accredited credit bureau within the last 6 months; • a copy of a valid certificate of insurance indicating liability insurance in the amount of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate; and • a letter of commitment from a financial institution (signed by an authorized agent of the financial institution and detailing the Proposer's name) for a general line of credit in the amount of five-hundred thousand dollars ($500,000.00).	**50**		
		B. 27 Provide the following as documentation of the Proposer's sufficient financial strength and resources to provide the scope of services as required: • Copies of its financial statements for the past three (3) years. If the CCN is a subsidiary of a parent organization, the CCN shall submit its financial statements or those of its parent, whichever are	**50**		

		available. If the CCN is a new entity, without a previous or parent entity, this requirement will be waived upon documentation of the performance bond and minimum net worth requirements. The financial statements must undergo an independent certified audit. The CCN is responsible for ensuring that this audit is performed. All audits should include: o The opinion of a certified public accountant; o A statement of revenue and expenses; o A balance sheet; o A statement of changes in financial position; and o A copy of all management letters; • Provide the following pro forma financial statements for the CCN Louisiana operation. The pro forma financial statements should be prepared on an accrual basis by month for the first three years beginning with the first month of the proposed execution date of the Contract: o A statement of monthly revenue and expenses; o A monthly cash flow analysis; and o A balance sheet for each month; o Provide copies of its bank statements for all its accounts; and • Provide a monthly enrollment and revenue projection corresponding to the pro forma financial statements referenced above. • The CCN shall provide a statement, signed by its president or chief executive officer, attesting that no assets of the CCN have been pledged to secure personal loans **Proposer shall include the Proposer's parent organization, affiliates, and subsidiaries.**			

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section C: Planned Approach to Project:	**100**		

		C.1 Describe how you will launch a network and set up operations capable of supporting its membership and meeting the requirements of the RFP by January 1, 2012 for GSA "A", March 1 of 2012 for GSA "B", or May 1 of 2012 for GSA "C".
		
		Discuss your approach for meeting the implementation requirements and include:
		
		• A detailed description of your project management methodology. The methodology should address, at a minimum, the following:
		  ○ Issue identification, assessment, alternatives analysis and resolution;
		  ○ Resource allocation and deployment;
		  ○ Reporting of status and other regular communications with DHH, including a description of your proposed method for ensuring adequate and timely reporting of information to DHH project personnel and executive management; and
		  ○ Automated tools, including use of specific software applications.
			15		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments

		C.2 Provide a work plan for the implementation of the Louisiana Medicaid CCN Program. At a minimum the work plan should include the following:
		
		• Tasks associated with your establishment of a "project office" or similar organization by which you will manage the implementation of the CCN Program;
		
		• An itemization of activities that you will undertake during the period between the awarding of this procurement and the start date of the CCN Program. These activities shall have established deadlines and timeframes and as needed conform to the timelines established under this RFP for deliverables.
		  o All activities to prepare for and participate in the Readiness Review Process; and
		  o All activities necessary to obtain required contracts for mandatory health care providers as specified in this RFP.
		
		• An estimate of person-hours associated with each activity in the Work Plan;
		
		• Identification of interdependencies between activities in the Work Plan; and
		
		• Identification of your expectations regarding participation by DHH and/or its agents in the activities in the Work Plan and dependencies between these activities and implementation activities for which DHH will be responsible. (In responding the CCN shall understand DHH shall not be obligated to meet the CCN's expectation.)
			30		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		C.3 Describe your Risk Management Plan. • At a minimum address the following contingency scenarios that could be encountered during implementation of the program: o Delays in building the appropriate Provider Network as stipulated in this RFP; o Delays in building and/or configuring and testing the information systems within your organization's Span of Control required to implement the CCN program; o Delays in hiring and training of the staff required to operate program functions; o Delays in the construction and/or acquisition of office space and the delivery of office equipment for staff required to operate program functions; o Delays in enrollment processing during the implementation of CCN; and o Delays in the publication of marketing and related materials and/or the delivery of these materials to DHH and/or its agents. • For each contingency scenario identified in the Proposal, at a minimum the Risk Management Plan must include the following: o Risk identification and mitigation strategies; o Risk management implementation plans; and o Proposed or recommended monitoring and tracking tools.	**25**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		C.4 Provide a copy of the Work Plan, generated in Microsoft Project or similar software product that includes the aforementioned implementation activities along with the timeframes, person-hours, and dependencies associated with these activities.	**20**		
		C.5 Provide a roster of the members of the proposed implementation team including the group that will be responsible for finalizing the Provider network.	**5**		
		C.6 Provide the resume of the Implementation Manager (the primary person responsible for coordinating implementation activities and for allocating implementation team resources).	**5**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section D: Member Enrollment and Disenrollment (Section 10 of the RFP)	**25**		
		D.1 Describe your enrollment procedure requirements, including how you will ensure that you will coordinate with DHH and its Agent.	**5**		
		D.2 Describe the types of interventions you will use prior to seeking to disenroll a Member as described in CCN Initiated Member Disenrollment, Section 12 of this RFP. If applicable, provide an example of a case in which you have successfully intervened to avert requesting the disenrollment of a member.	**15**		
		D.3 Describe the steps you will take to assign a member to a different Provider in the event a PCP requests the Member be assigned elsewhere.	**5**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section E: Chronic Care/Disease Management (Section 7 of RFP)	**100**		
		E.1 Describe existing (other state Medicaid or CHIP contracts) and planned Chronic Care/Disease Management programs for the Louisiana CCN Program that are designed to improve health care outcomes for members with one or more chronic illnesses. Describe how the Chronic Care/Disease Management programs' data are analyzed and the results utilized by your organization to improve member outcomes.	**50**		
		E.2 Describe how recipients will be identified for inclusion into the Chronic Care/Disease Management program. Identify which disease states/ recipient types will be targeted for the Chronic Care/Disease Management program. Describe how the Chronic Care/Disease Management program will coordinate information and services with the PCP.	**50**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section F: Service Coordination (Section 7 of RFP)	**160**		
		F.1 DHH intends to provide CCNs with two years of historic claims data for members enrolled in the CCN effective the start date of operations. Describe how you will ensure the continuation of medically necessary services for members with special health needs who are enrolled in your CCN effective the start date of operations. The description should include: • How you will identify these enrollees, and how you will use this information to identify these enrollees, including enrollees who are receiving regular ongoing services; • What additional information you will request from DHH, if any, to assist you in ensuring continuation of services; • How you will ensure continuation of services, including prior authorization requirements, use of non-contract providers, and transportation; • What information, education, and training you will provide to your providers to ensure continuation of services; and • What information you will provide your members to assist with the transition of care.	**10**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		F.2 Describe your approach to CCN case management. In particular, describe the following: • Characteristics of members that you will target for CCN case management services; • How you identify these members; • How you encourage member participation; • How you assess member needs; • How you develop and implement individualized plans of care, including coordination with providers and support services; • How you coordinate your disease management and CCN case management programs; • How you will coordinate your case management services with the PCP; • How you will assist in providing access to specialist for medically necessary services; and • How you will incorporate provider input into strategies to influence behavior of members.	**85**		
		F.3 Describe your approach for coordinating Louisiana Medicaid State Plan services which will continue to be provided by the Medicaid fee-for-service program.	**5**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		F.4 Aside from transportation, what specific measures will you take to assist members in rural parishes are able to access specialty care? Also address specifically how will you ensure members with disabilities have access?	**10**		
		F.5 Detail the strategies you will use to influence the behavior of members to access health care resources appropriately and adapt healthier lifestyles. Include examples from your other Medicaid/CHIP managed care contracts as well as your plan for Louisiana Medicaid CCN members.	**40**		
		F.6 Many faith based, social and civic groups, resident associations, and other community-based and governmental organizations now feature health education and outreach activities, incorporate health education in their events, and provide direct medical services (e.g., through visiting nurses, etc.). Describe what specific ways would you leverage these resources to support the health and wellness of your members.	**10**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section G: Provider Network (Section 9 of RFP)	**110**		
		G.1 Provide a listing of the proposed providers network, including those providers with whom you have obtained a signed LOI or executed subcontract. LOIs and signed subcontracts will receive equal consideration. LOIs and subcontracts should NOT be submitted with the proposal. DHH may verify any or all referenced LOIs or contracts. Along with the provider listing, provide the number of potential linkages per PCP. Using providers, with whom you have signed letters of intent or executed contracts, provide individual GeoAccess maps and coding by GSA. You should provide individual maps as well as overlay maps to demonstrate distance relationships between provider types, if appllicable.	**15**		
		G.2 Describe how you will handle the potential loss of a large PCP group or practice. .	**5**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		G.4 Describe your process for monitoring and ensuring adherence to DHH's requirements regarding appointments and wait times.	**5**		
		G.5 Describe your PCP assignment process and the measures taken to ensure that every member in your CCN is assigned a PCP in a timely manner. Include your process for permitting members with chronic conditions to select a specialist as their PCP and whether you allow specialists to be credentialed to act as PCPs.	**5**		
		G.6 Describe your plan for working with PCPs to obtain NCQA medical home recognition or JCAHO Primary Home accreditation and meeting the requirements of Section 14.	**5**		
		G.7 Describe how you will monitor providers and ensure compliance with provider subcontracts. In addition to a general description of your approach, address each of the following: o Compliance with cost sharing requirements (see, Sections 19); o Compliance with medical record documentation standards; (Section 15) o Compliance with conflict of interest requirements (see, Sections 19); o Compliance with lobbying requirements (Sections 19); o Compliance with disclosure requirements in (Section 19); and o Compliance with marketing requirements (Section 11).	**5**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		G.8 Provide an example from your previous experience of how you have handled provider noncompliance with contract requirements, if applicable	**5**		
		G.9 Describe in detail how you will educate and train providers about billing requirements, including both initial education and training prior to the start date of operations and ongoing education and training for current and new providers. Describe how you will educate and train providers that join your network after program implementation. Identify the key requirements that will be addressed	**10**		
		G.10 Describe your practice of profiling the quality of care delivered by network PCPs, and any other acute care providers (e.g., high volume specialists, hospitals), including the methodology for determining which and how many Providers will be profiled. o Submit sample quality profile reports used by you, or proposed for future use (identify which). o Describe the rationale for selecting the performance measures presented in the sample profile reports. o Describe the proposed frequency with which you will distribute such reports to network providers.	**15**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		G.11 Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the provider grievance and appeal process.	**10**		
		G.12 Describe how Louisiana-based providers will be will be involved in the operations and decision making of the CCN decision making. This includes medical as well as financial operations such as medical decisions and savings distribution.	**10**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section H: Utilization Management (UM) (Section 7 of RFP)	**80**		
		H.1 Describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan.	**30**		
		H.2 If the UM guidelines were developed internally, describe the process by which they were developed and when they were developed or last revised.	**10**		

		H.3 Regarding your utilization management (UM) staff:
		• Provide a detailed description of the training you provide your UM staff;
		• Describe any differences between your UM phone line and your member services line with respect to bullets (2) through (7) in item L.1;
		• If your UM phone line will handle both Louisiana CCN and non-Louisiana CCN calls,
		  ○ explain how you will track CCN calls separately; and
		  ○ how you will ensure that applicable DHH timeframes for prior authorization decisions are met.
			20		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		H.4 Describe how utilization data is gathered, analyzed, and reported. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider and a member. Provide an example of how your analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system.	**20**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section I: EPSDT(Section 7 of RFP)	**25**		
		I.1 Describe your system for tracking each member's screening, diagnosis, and treatment including, at minimum, the components of the system, the key features of each component, the use of technology, and the data sources for populating the system.	**5**		
		I.2 Describe your approach to member education and outreach regarding EPSDT including the use of the tracking system described in I.1 above and any innovative/non-traditional mechanisms. Include: • How you will conduct member education and outreach regarding EPSDT including any innovative/non-traditional methods that go beyond the standard methods; • How you will work with members to improve compliance with the periodicity schedule, including how you will motivate parents/members and what steps you will take to identify and reach out to members (or their parents) who have missed screening appointments (highlighting any innovative/non-traditional approaches); and How you will design and monitor your education and outreach program to ensure compliance with the RFP.	**10**		
		I.3 Describe your approach to ensuring that providers deliver and document all required components of EPSDT screening.	**5**		
		I.4 Describe how you will ensure that needs identified in a screening are met with timely and appropriate services.	**5**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section J: Quality Management (Section 7 of RFP)	**115**		
		J.1 Document experience in other States to positively impact the healthcare status of Medicaid and or CHIP populations. Examples of areas of interest include, but are not limited to the following: • Management of high risk pregnancy • Reductions in low birth weight babies • Pediatric Obesity (children under the age of 19) • Reduction of inappropriate utilization of emergent services • EPSDT • Children with special health care needs • Asthma • Diabetes • Cardiovascular diseases • Reduction in racial and ethnic health care disparities to improve health status • Hospital readmissions and avoidable hospitalizations	**30**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		J.2 Describe how you will identify quality improvement opportunities. Describe the process that will be utilized to select a performance improvement project, and the process to be utilized to improve care or services. Include information on how interventions will be evaluated for effectiveness. Identify proposed members of the Quality Assessment Committee.	**15**		
		J.3 Provide a description of focus studies performed, quality improvement projects, and any improvements you have implemented and their outcomes. Such outcomes should include cost savings realized, process efficiencies, and improvements to member health status. Such descriptions should address such activities since 2001 and how issues and root causes were identified, and what was changed.	**15**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments

		J.4 Describe your proposed Quality Assessment and Improvement Program (QAIP). Such description should address:
		• The QAIPs proposed to be implemented during the term of the contract.
		• How the proposed QAIP s will expand quality improvement services.
		• How the proposed QAIP will improve the health care status of the Louisiana Medicaid population.
		• Rationale for selecting the particular programs including the identification of particular health care problems and issues identified within the Louisiana Medicaid population that each program will address and the underlying cause(s) of such problems and issues.
		• How your will keep DHH informed of QAPI program actions, recommendations and outcomes on an ongoing and timely manner.
		• How the proposed QAIPs may include, but is not necessarily, limited to the following:
		  o New innovative programs and processes.
		  o Contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts and/or School Based Health Clinics.
			20		

		J.5 Describe how feedback (complaints, survey results, CCN Consumer/Provider Committee, etc.) from members and providers will be used to drive changes and/or improvements to your operations. Provide a member and a provider example of how feedback has been used by you to drive change in other Medicaid managed care contracts.	**10**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		J.6 Provide, in Excel format, the Proposer's results for the HEDIS measures specified below for the last three measurement years (2007, 2008, and 2009) for each of your State Medicaid contracts. • If you do not have results for a particular measure or year, provide the results that you do have. • If you do not have results for your Medicaid product line in a state where you have a Medicaid contract, provide the commercial product line results with an indicator stating the product line. • If you do not have Medicaid HEDIS results for at least five states, provide your commercial HEDIS measures for your largest contracts for up to five states (e.g., if you have HEDIS results for the three states where you have a Medicaid contract, you only have Medicare HEDIS for one other state, provide commercial HEDIS results for another state). • If you do not have HEDIS results for five states, provide the results that you do have. • In addition to the spreadsheet, please provide an explanation of how you selected the states, contracts, product lines, etc. that are included in the spreadsheet and explain any missing information (measure, year, or Medicaid contract). **Include the Proposer's parent organization, affiliates, and subsidiaries.** Provide results for the following HEDIS measures: • Adults' Access to Preventive/Ambulatory Health Services • Comprehensive Diabetes Care- HgbA1C component • Chlamydia Screening in Women • Well-Child Visits in the 3,4,5,6 years of life	**25**		

		• Adolescent well-Care. • Ambulatory Care - ER utilization • Childhood Immunization status • Breast Cancer Screening • Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care) • Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents			

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section K: Member Materials (Section 11 of RFP)	**50**		
		K.1 Describe proposed content for your member educational materials) and attach examples used with Medicaid or CHIP populations in other states.	**15**		
		K.2 Describe how you will ensure that all written materials meet the language requirements and which reference material you anticipate you will use to meet the sixth (6th) grade reading level requirement.	**5**		
		K.3 Describe your process for producing Member ID cards and information that will accompany the card. Include a layout of the card front and back. Explain how you will ensure that a Member receives a new Member ID Card whenever there has been a change in any of the information appearing on the Member ID Card.	**10**		
		K.4 Describe your strategy for ensuring the information in your provider directory is accurate and up to date, including the types and frequency of monitoring activities and how often the directory is updated.	**10**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		K.5 Describe how you will fulfill Internet presence and Web site requirements, including: • Your procedures for up-dating information on the Web site; • Your procedures for monitoring e-mail inquiries and providing accurate and timely responses; and • The procedures, tools and reports you will use to track all interactions and transactions conducted via the Web site activity including the timeliness of response and resolution of said interaction/transaction.	10		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section L: Customer Service (Section 11 of RFP)	**100**		
		L.1 Provide a narrative with details regarding your member services line including: ○ Training of customer service staff (both initial and ongoing); ○ Process for routing calls to appropriate persons, including escalation; (3) The type of information that is available to customer service staff and how this is provided (e.g., hard copy at the person's desk or on-line search capacity); ○ Process for handling calls from members with Limited English Proficiency and persons who are hearing impaired; ○ Monitoring process for ensuring the quality and accuracy of information provided to members; ○ Monitoring process for ensuring adherence to performance standards; ○ How your customer service line will interact with other customer service lines maintained by state, parish, or city organizations (e.g Partners for Healthy Babies, WIC, housing assistance, and homeless shelters); and ○ After hours procedures.	**25**		
		L.2 Provide member hotline telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as of January 1, 2011 for the most recent four (4) quarters, with data that show the monthly call volume, the trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system) and the monthly trends for the 1 rate, if applicable.	**25**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		L.3 Describe the procedures a Member Services representative will follow to respond to the following situations: o A member has received a bill for payment of covered services from a network provider or out-of-network provider; o A member is unable to reach her PCP after normal business hours; o A Member is having difficulty scheduling an appointment for preventive care with her PCP; and o A Member becomes ill while traveling outside of the GSA.	**20**		
		L.4 Describe how you will ensure culturally competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.	**15**		
		L.5 Describe how you will ensure that covered services are provided in an appropriate manner to members with Limited English proficiency and members who are hearing impaired, including the provision of interpreter services.	**15**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section M: Emergency Management Plan (Section 3 of RFP)	**25**		
		M.1 Describe your emergency response continuity of operations plan. Attach a copy of your plan or, at a minimum, summarize how your plan addresses the following aspects of pandemic preparedness and natural disaster recovery: o Employee training; o Identified essential business functions and key employees within your organization necessary to carry them out; Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable; o Communication with staff and suppliers when normal systems are unavailable; o Specifically address your plans to ensure continuity of services to providers and members; and o How your plan will be tested.	**15**		
		M.2 Describe your plan in the following Emergency Management Plan scenario for being responsive to DHH, to members who evacuate, to network providers, and to the community. • You have thirty thousand (30,000) or more CCN members residing in hurricane prone parishes. All three GSAs include coastal parish and inland parishes subject to mandatory evacuation orders during a major hurricane. A category 5 hurricane is approaching, with landfall predicted in 72 hours and parishes within the GSA are under a mandatory evacuation order. State	**10**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		assisted evacuations and self evacuations are underway. Members are evacuated to or have evacuated themselves to not only all other areas of Louisiana, but to other States. • Your provider call center and member call center are both located in Baton Rouge and there is a high likelihood of high winds, major damage and power outages for 4 days or more in the Baton Rouge Area (reference Hurricane Gustav impact on Baton Rouge). It is expected that repatriation of the evacuated, should damages be minimal, will not occur for 14 days. If damage is extensive, there may be limited repatriation, while other members may be indefinitely relocated to other areas in Louisiana or other states.			

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section N: Grievances (Section 12 of RFP)	**25**		
		N.1 Provide a flowchart (marked as Chart C) and comprehensive written description of your member grievance process, including your approach for meeting the general requirements and plan to: o Ensure that the Grievance System policies and procedures, and all notices will be available in the Member's primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal; o Ensure that individuals who make decisions on Grievances have the appropriate expertise and were not involved in any previous level of review; and o Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member's health. As part of this process, explain how you will determine when the expedited process is necessary. Include in the description how data resulting from the grievance system will be used to improve your operational performance.	**25**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section O: Fraud & Abuse (Section 15 of RFP)	**15**		
		O.1 Describe your approach for meeting the program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Discuss your approach for meeting the coordination with DHH and other agencies requirement.	**15**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section P: Claims Management (Section 14 of RFP)	**80**		
		P.1 Describe the capabilities of your claims management systems as it relates to each of the requirements as specified in Electronic Claims Management Functionality Section and the Adherence to Key Claims Management Standards Section. In your response explain whether and how your systems meet (or exceed) each of these requirements. Cite at least three examples from similar contracts.	**30**		
		P.2 Describe your methodology for ensuring that claims payment accuracy standards will be achieved per, Adherence to Key Claims Management Standards Section. At a minimum address the following in your response: • The process for auditing a sample of claims as described in Key Claims Management Standards Section; • The sampling methodology itself; • Documentation of the results of these audits; and • The processes for implementing any necessary corrective actions resulting from an audit.	**25**		
		P.3 Describe your methodology for ensuring that the claims pre-processing, including adherence to all service authorization procedures, are met.	**25**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section Q: Information Systems (Section 13 of RFP)	**200**		

		Q.1 Describe your approach for implementing Management Information Systems in support of this RFP, including:
		• Capability and capacity assessment to determine if new or upgraded systems, enhanced systems functionality and/or additional systems capacity are required to meet contract requirements;
		• Configuration of systems (e.g., business rules, valid values for critical data, data exchanges/interfaces) to accommodate contract requirements;
		• System setup for intake, processing and acceptance of one-time data feeds from the State and other sources, e.g., initial set of CCN enrollees, claims/service utilization history for the initial set of CCN enrollees, active/open service authorizations for the initial set CCN enrollees, etc.; and
		• Internal and joint (CCN and DHH) testing of one-time and ongoing exchanges of eligibility/enrollment, provider network, claims/encounters and other data.
		• Provide a Louisiana Medicaid CCN-Program-specific work plan that captures:
		  o Key activities and timeframes and
		  o Projected resource requirements from your organization for implementing information systems in support of this contract.
		• Describe your historical data process including but not limited to:
			25		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		○ Number of years retained; ○ How the data is stored; and ○ How accessible it is. The work plan should cover activities from contract award to the start date of operations.			
		Q.2 Describe the ability within your systems to meet (or exceed) each of the requirements in Section 16 of the RFP and the CCN-P Systems Companion Guide. Address each requirement. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.	**15**		
		Q.3 Describe in detail how your organization will ensure that the availability of its systems will, at a minimum, be equal to the standards set forth in the RFP. At a minimum your description should encompass: information and telecommunications systems architecture; business continuity/disaster recovery strategies; availability and/or recovery time objectives by major system; monitoring tools and resources; continuous testing of all applicable system functions, and periodic and ad-hoc testing of your business continuity/disaster recovery plan. Identify the timing of implementation of the mix of technologies and management strategies (policies and procedures) described in your response to (a), or indicate whether these technologies and management strategies are already in place. Elaborate, if applicable, on how you have successfully implemented the aforementioned mix of technologies and management strategies with other clients.	**15**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Q.4 Describe in detail: • How your *key production systems* are designed to *interoperate*. In your response address all of the following: o How identical or closely related data elements in different systems are named, formatted and maintained: - Are the data elements named consistently; - Are the data elements formatted similarly (# of characters, type-text, numeric, etc.); - Are the data elements updated/refreshed with the same frequency or in similar cycles; and - Are the data elements updated/refreshed in the same manner (manual input, data exchange, automated function, etc.). o All exchanges of data between key production systems. - How each data exchange is triggered: a manually initiated process, an automated process, etc. - The frequency/periodicity of each data exchange: "real-time" (through a live point to-point interface or an interface "engine"), daily/nightly as triggered by a system processing job, biweekly, monthly, etc. • As part of your response, provide diagrams that illustrate: o point-to-point interfaces, o information flows, o internal controls and o the networking arrangement (AKA "network diagram") associated with the information systems profiled. These diagrams should provide insight into how your Systems will be organized and interact with DHH systems for the purposes of exchanging Information and	**15**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		automating and/or facilitating specific functions associated with the Louisiana Medicaid CCN Program.			
		Q.5 Describe your ability to provide and store service/prior authorization data in accordance with the requirements in this RFP. In your response: • Explain whether and how your systems meet (or exceed) each of these requirements. • Cite at least three currently-live instances where you are successfully providing service/prior authorization functions in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications. Explain how previous or current experience will apply to the Louisiana Medicaid CCN Program. • If you are not able at present to meet a particular requirement contained in the RFP, identify the applicable requirement and discuss the effort and time you will need to meet said requirement. (4) Identify challenges and "lessons learned" from your implementation and operations experience in other states and describe how you will apply these lessons to this contract.	**15**		
		Q.6 Describe your ability to receive, process, and update eligibility/enrollment, provider data, and claims data to and from the Department and its agents; in accordance with the requirements in Section 14. In your response: • Explain whether and how your systems meet (or exceed) each of these requirements.	**15**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		• Cite at least three currently-live instances where you are successfully receiving, processing and updating eligibility/enrollment data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications. In elaborating on these instances, address all of the requirements in Section 14. Also, explain how that experience will apply to the Louisiana Medicaid CCN Program. • If you are not able at present to meet a particular requirement contained in the aforementioned sections, identify the applicable requirement and discuss the effort and time you will need to meet said requirement. • Identify challenges and "lessons learned" from implementation in other states and describe how you will apply these lessons to this contract.			
		Q.7 Describe the ability within your systems to meet (or exceed) each of the requirements in Section 13 - System and Technical Requirements. Address each requirement. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.	**15**		
		Q.8 Describe your information systems change management and version control processes. In your description address your production control operations.	**10**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Q9 Describe your approach to demonstrating the readiness of your Management Information systems to DHH prior to the start date of operations. At a minimum your description must address: • provider contract loads and associated business rules; • eligibility/enrollment data loads and associated business rules; and • claims processing and adjudication logic.	**15**		
		Q.10 Describe your reporting and data analytic capabilities including: • generation and provision to DHH of the management reports prescribed in the RFP; • generation and provision to the State of reports on request; • the ability in a secure, inquiry-only environment for authorized DHH staff to create and/or generate reports out of your systems on an *ad-hoc* basis; and • Reporting back to providers within the network.	**15**		
		Q.11 Provide a detailed profile of the key information systems within your span of control.	**5**		
		Q.12 Provide a profile of your current and proposed Information Systems (IS) organization.	**5**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Q.13 Describe what you will do to promote and advance electronic claims submissions and assist providers to accept electronic funds transfers.	**5**		
		Q.14 Indicate how many years your IT organization or software vendor has supported the current or proposed information system software version you are currently operating. If your software is vendor supported, include vendor name(s), address, contact person and version(s) being used.	**Included/Not Included**		
		Q.15 Describe your plans and ability to support network providers' "meaningful use" of Electronic Health Records (EHR) and current and future IT Federal mandates. Describe your plans to utilizing ICD-10 and 5010.	**15**		
		Q.16 Describe the procedures that will be used to protect the confidentiality of records in DHH databases, including records in databases that may be transmitted electronically via e-mail or the Internet.	**10**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section R: Added Value to Louisiana If you are awarded a contract, the response to this section will become part of your contract with DHH and DHH will confirm your compliance. The incentives and enhanced payments, for providers and expanded benefits to members proposed herein cannot be revised downward during the initial thirty-six (36) month term of the contract, as such programs were considered in the evaluation of the Proposal. Increases in payments or benefits during the term of the contract may be implemented.	**100**		
		R.1 The "value added" from Provider Incentive Payments will be considered in the evaluation of Proposals. Responses to this section (which can be considered Proprietary) will be evaluated based solely on the quantified payment amounts reported herein, based on projected utilization for 75,000 members, and within the guidelines of the CCN program. Any cost savings associated with any quality or incentive program shall not be included in this response and will not be considered in the evaluation of this factor. See Appendix HH for instructions for completing the Provider Incentive Payments for Provider Incentives	**100**		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		and Enhanced Payments. The completed template (Attachment FF) and all additional documentation and calculations shall be accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information.			

Appendix CC

ePCCM Breakdown of Tasks

CCN-S ePCCM Breakdown of Tasks

	Enhanced Primary Care Case Management Tasks	Responsibility: ePCCM — Included in ePCCM Rate Range	Responsibility: PCP — Included in $3.00 PCP fee
1.00	**PRIOR AUTHORIZATION**		
1.01	Conduct utilization management and implement prior authorization process consistent with the Department's prior authorization process	X	X
1.02	Assure that covered services are sufficient in amount, duration, and scope that is no less than the amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished and that services are not arbitrarily denied or reduced in amount, duration or scope solely because of diagnosis, type of illness, or condition of the enrollee.	X	
1.03	Have in effect mechanisms to ensure consistent application of review criteria for decisions and if any decision is made to deny an authorization request or it is authorized in an amount duration or scope that is less than requested, the decision is made by a health care professional who has appropriate clinical expertise in treating the disease of condition.	X	
1.04	Provide a notice of action as Yes in 438.210(c) and (d)	X	
1.05	Evaluation of medical necessity appropriateness and efficiency of use of health care services and facilities	X	X
1.06	Manage utilization through practice protocols. Adopt, disseminate and apply guidelines as described in 42CFR 438.236.	X	X
1.07	Yes additional services requiring prior authorization for which the Department does not require prior authorization	X	X
1.08	Provide prior authorization file to State FI that can interface with State Claim processing system	X	
1.09	Produce and review reports to identify over and under utilization and develop action plans to address if identified	X	
2.00	**PATIENT CENTERED MEDICAL HOME**		
2.01	Facilitate NCQA PCMH recognition of PCP practices	X	
2.02	Have written standards for patient access	X	X
2.03	Written standards for patient communication		X
2.04	Use data to show meeting standards on patient access and communication information		X
2.05	Use EMR charting tools to organize clinical information as outlined in NCQA guidelines		X
2.06	Use data to identify important diagnoses and conditions in practice		X
2.07	Implement evidence-based guidelines for at least three conditions		X
2.08	Actively support patient self-management		X
2.09	Track test and identifies abnormal results systematically		X
2.10	Track referrals using a paper-based or electronic system		X
2.11	Measure clinical or service performance by physician or across practice	X	X
2.12	Report performance by physician or across practice	X	X
2.13	Monitor progression of providers regarding implementation of PCMHs	X	
2.14	Provide participating practices with technology support to assist the practices in transition to PCMH (including education, training tools, provision of data relevant to patient clinical care management	X	
2.15	Promote and facilitate capacity of PCPs to meet PCMH certification requirements	X	
2.16	Develop a PCMH Implementation Plan	X	
2.17	Document evidence and report on PCMH certification by practices	X	
2.18	Develop and complete evaluation of PCMH providers including metrics for evaluating achievement of outcomes, patient experiences and costs	X	
2.19	Facilitate specialist provider networks access and coordination to support PCMH model	X	
2.20	Include PCMH requirements in PCP/PCCM contracts	X	
2.21	Facilitate data interchange between PCP/PCCM, specialists, labs, radiology and hospitals	X	

CCN-S ePCCM Breakdown of Tasks

	Enhanced Primary Care Case Management Tasks	Responsibility: ePCCM — Included in ePCCM Rate Range	Responsibility: PCP — Included in $3.00 PCP fee
2.22	Participate in Patient Centered Primary Care Collaborative activities	X	X
3.00	**CARE COORDINATION**		
3.01	Coordinate and refer and any prior authorization services for IP, OP, Lab, Radiology, EPSDT, therapy services, BH, etc.	X	X
3.02	Care coordinators must ensure that Enrollees have access to all Covered Services appropriate to the Enrollee's condition or circumstance and to act as a liaison with various government agencies and programs, public entities, county entities and community resources. Coordinate the services provided to the enrollees with any other MCO with whom the enrollee has coverage.	X	X
3.03	Establish relationships, make referrals and coordinate services with Government agencies (MH/DD agencies, juvenile probation, etc.)	X	
3.04	Coordinate referrals and medically necessary f/u resulting from EPSDT screens	X	X
3.05	Make 3 attempts to ensure that members under 21 have scheduled their EPSDT screening	X	X
3.06	Provide outreach to members who miss appointments and remind them of importance of keeping scheduled appointments	X	X
3.07	Assist PCPs with scheduling referral appointments	X	X
3.08	Identify BH diagnoses and issues and make referrals to BH providers as appropriate.		X
3.09	F/U with members using ED for non-emergent conditions	X	X
3.10	Identify when an enrollee on their panel has excessive use of ED	X	
3.11	Administrative and field care coordinators must facilitate communication and coordinate service delivery between primary care, specialty ancillary and BH providers to ensure timely and uninterrupted access to care.	X	X
4.00	**CASE MANAGEMENT AND CHRONIC CARE MANAGEMENT**		
4.01	Must ensure a sufficient number and level of expertise in the CM staff	X	
4.02	Identify enrollees with special needs who need CM services or referral	X	X
4.03	Identify those with special health care needs and have a mechanism by which they may directly access a specialist.		X
4.04	Medical Director will serve as an advocate for the program, identify key stakeholders in the community and create strategic relationships to ensure success	X	
4.05	Medical director will report any barriers to success, take an active leadership role on Committees, and participate in meetings with the CM staff and physician practices	X	
4.06	Develop and implement Chronic Care Management Program (CCMP) for conditions identified by the Department and other conditions as necessary for achieving outcomes	X	X
4.07	CCMP program must emphasize prevention of exacerbation and complications using evidence based clinical practice guidelines, patient empowerment and activation strategies	X	X
4.08	ID members for outreach by analysis of claims data, referrals, predictive modeling	X	
4.09	Engage enrollees with eligible conditions	X	X
4.10	Encourage evaluation of clinical, humanistic and economic outcomes, addressing co-morbidities through whole person approach		X
4.11	Identify community resources and arrange referral processes	X	X
4.12	Develop and distribute education materials (brochures, handbooks, newsletters, video tapes, etc.)	X	
4.13	Manage all co-morbidities including those not in DM eligible conditions		X
4.14	Apply a risk stratification methodology to enrollees engaged in program	X	X

CCN-S ePCCM Breakdown of Tasks

	Enhanced Primary Care Case Management Tasks	Responsibility: ePCCM — Included in ePCCM Rate Range	Responsibility: PCP — Included in $3.00 PCP fee
4.15	Deploy staff in the field to contact members without phones or not responding to phone calls	X	
4.16	Address Health Literacy and alternative device (for visually, speech or hearing impaired) issues in communication and education offerings	X	X
4.17	Provide report informing provider of enrollee compliance with self-management care plans; gaps between recommended and actual care provided to enrollees; enrollee's health status, utilization statistics	X	
4.18	If CCMP does not improve outcomes submit CAP designed to achieve the objectives of the CCMP program	X	
4.19	Conduct education and outreach to providers on Clinical Practice Guidelines, new technologies, and best practices in treating chronic disease prevalent in the population who are covered in the CCMP	X	
5.00	**CUSTOMER SERVICE**		
5.01	Maintain toll-free customer service 7am - 7pm M-F	X	
5.02	Maintain grievance system that processes grievances and appeals and provides state fair hearings as described in 42 CFR Subpart F.	X	
5.03	Inform individuals of grievance process, if any, and how to access state fair hearing process	X	
5.04	Give written notice of termination of a contracted PCP within 15 days	X	
5.05	Provide enrollees with contacts for non-English providers and providers not accepting new Medicaid clients, obtaining care after-hours, emergency coverage and referrals to specialists	X	
5.06	Disseminate Department approved enrollee materials	X	
5.07	Provide information with translations, interpretation and in alternative formats as Yes in 42 CFR 438.10 (c) and (d).	X	
5.08	Provide enrollees information in accordance with 42 CFR 438.10(f) and (g) including covered services, prior authorization process for accessing services; how to access out of network services; policy on referral process for specialty care; cost sharing; process for obtaining services not covered by plan but available under SP and grievance, appeal and state fair hearing procedures and timeframes.	X	
5.09	Provide information to potential enrollees when requested as described in 438.10 (e)	X	
5.10	Have written policies that cover enrollee rights and protections as are specified in 42CFR 438.100 (b). The MCO must ensure that its staff and affiliated providers take these rights into account when providing services.	X	
5.11	Maintain assignments to individual PCPs with the CCPN network	X	
5.12	To the extent possible allow enrollees to choose their health professional.	X	
5.13	The MCO may not request disenrollment of enrollees when there is an adverse change in their health status, because of their utilization of services, diminished mental capacity or uncooperative or disruptive behavior resulting from his or her special needs.	X	
5.14	In accordance with 42 CFR 438.6(i) maintain policies and procedures covering advance directives. Provide adult enrollees with written information about these policies and a description of applicable State law. Educational materials should also be provided to the community.	X	
5.15	Call center scripts must be made and approved by the Department for Welcome calls, outbound calls as well as when an Enrollee would like to change a PCP	X	
5.16	Monitor and report accessibility of call center operations	X	

CCN-S ePCCM Breakdown of Tasks

	Enhanced Primary Care Case Management Tasks	Responsibility: ePCCM — Included in ePCCM Rate Range	Responsibility: PCP — Included in $3.00 PCP fee
5.17	Send welcome packet to enrollees and make welcome calls to enrollees X to X days after the effective date of enrollment; making 3 attempts to contact the enrollee and must use script that was previously approved by the Department	X	
5.18	Conduct orientation program for 'new' enrollees; assist non-English speaking members with orientation; Establish communication standards for non-English speaking members	X	
6.00	**QUALITY MANAGEMENT, REPORTING, COMPLIANCE AND FRAUD MONITORING**		
6.01	Maintain a written QM implementation plan, program description and work plan	X	
6.02	Select one Performance Improvement Projects (PIPs) from an approved list developed by the Department to implement in year one, and another PIP will be mandated in year one by the Department (for a total of two). The Department will define the number of PIPs and selection process in subsequent years.	X	
6.03	Participate in pharmacy initiatives to contain costs and improve quality, ensure compliance with PDL	X	
6.04	Run, review and disseminate reports detailing practice patterns that will ensure appropriate care.	X	
6.05	Facilitate provider participation in periodic external chart reviews to monitor effectiveness of QI initiatives	X	
6.06	Must review P&Ps annually and update them as Yes by the Department who must approve any amendment, update, or change	X	
6.07	Implement, track, monitor, and report a complaint process which includes review, timeframe and resolution	X	
6.08	Report complaints to the Department	X	
6.09	Conduct annual Medical Record reviews of a sampling of PCPs assessing the provider medical records for a set of factors mutually agreed upon by the department and the CCPN	X	
6.10	Have a Quality Management Committee that includes department staff to ensure coordination between the vendors to ensure access	X	
6.11	Monitor PCP/PCCM performance and provide feedback to the PCP/PCCM	X	
6.12	Administer annual CAHPS satisfaction/consumer experience survey	X	
6.13	Administer annual Provider satisfaction survey (methodology approved by the Department	X	
6.14	Evaluate QM Program annually	X	
6.15	Must prepare meeting minutes and submit the minutes for approval within 10 business days	X	
6.16	Maintain an ongoing log of issues discussed during the meetings	X	
6.17	Quality Management staff must coordinate the quality management activities and act as liaisons to the Department on all quality related materials, tasks and initiatives as approved by the Department	X	
6.18	Attend Department Meetings	X	
6.19	Collect and report on Quality Management performance measures including mandatory HEDIS, AHRQ and other measures	X	
6.20	Oversee and be accountable for any functions and responsibilities that are delegated to any contractor as described in 42 CFR 438.230.	X	
7.00	**REPORTING**		
7.01	Provide financial reports as requested by the Department	X	
7.02	Notify Department within 15 days of any change in CCPN organizational structure or staffing levels	X	
7.03	Make available all records to CMS, OIG, GAO, and the Department for inspection, evaluation and audit	X	

CCN-S ePCCM Breakdown of Tasks

	Enhanced Primary Care Case Management Tasks	Responsibility: ePCCM Included in ePCCM Rate Range	Responsibility: PCP Included in $3.00 PCP fee
7.04	Disseminate reports detailing practice patterns to PCPs/PCCMS	X	
7.05	Ensure standardized claims data is submitted by all providers	X	X
7.06	Must maintain books, records, documents and other evidence pertaining to all revenues, expenditures, and other financial activity for 5 years	X	
7.07	Provide Department with reports requested by Department in writing in the manner, form and time periods specified by Department	X	
7.08	Report on performance metrics including: HEDIS, AHRQ, CAHPS, Grievance Reports	X	
8.00	**COMPLIANCE PROGRAM**		
8.01	Have a mandatory Compliance Plan, Officer and Committee as detailed in 42CFR 438.608.	X	
8.02	Maintain written P&Ps and safeguards for use of and maintaining the confidentiality of data	X	
8.03	Develop a Fraud and Abuse program to detect and prevent F/A and report to the MFCU	X	
8.04	Cooperate with oversight agencies responsible for F/A detection	X	
8.05	Ensure that all subcontractors take actions as necessary to permit the vendor to comply with the F/A requirements	X	
8.06	Have an Emergency Preparedness Plan	X	
8.07	Have process in place to report any act by providers/members/employees that may affect the integrity of the CCPN program and report quality issues within x business days of ID of the issue	X	
9.00	**PROVIDER MONITORING AND SERVICES**		
9.01	Develop network to provide services to individuals deemed eligible by the Department in the geo area	X	
9.02	Do not discriminate against providers based solely on their licensure or certification as described in 42 CFR 438.12 (a) and (b). or against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. If the MCO declines to include providers in its network but give written notice to the provider with the reason for its decision.	X	
9.03	Accept enrollee file and handle requests to transfer to new PCP within the network	X	
9.04	Follow a documented process for credentialing and recredentialing of providers who have signed contracts	X	
9.05	Provide female enrollees with direct access to women's health specialists within the network for women's routine and preventive health care services.	X	
9.06	Provide a second opinion for a qualified health care professional within the network or arrange for one outside the network.	X	
9.07	Do not prohibit or otherwise restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is their patient.	X	
9.08	Assure appropriate expenditure of administrative fees	X	
9.09	Conduct routine provider monitoring to ensure access	X	
9.10	Monitor PCP/PCCM compliance with CCPN policies	X	
9.11	Facilitate data interchange between practices and the ePCCM and the Departments	X	
9.12	Work with providers to reconcile problems	X	
9.13	Develop and distribute provider manuals	X	
9.14	Monitor appointment availability standards	X	
9.15	Provide providers with educational and technical support	X	

CCN-S ePCCM Breakdown of Tasks

	Enhanced Primary Care Case Management Tasks	Responsibility	
		ePCCM	PCP
		Included in ePCCM Rate Range	Included in $3.00 PCP fee
9.16	Ensure that PCPs do not refuse to serve enrollees for reasons that would be discriminatory	X	
9.17	Must educate providers on the process to request an Enrollee reassignment to another PCP	X	
9.18	Will work with the Department to determine outlier prescribers to make sure they are prescribing drugs appropriately	X	
10.00	**PAY FOR PERFORMANCE**		
10.01	Administer a Physician Performance Incentive Program (PPIP)	X	
10.02	Implement formal agreements, clearly articulating distribution of shared savings, PPIP, or other incentive measures	X	
10.03	Develop and implement incentive plan to reward quality and performance of practicing PCPs/PCCMS	X	
11.00	**INFORMATION SYSTEMS**		
11.01	Facilitate data interchange between practices and the CCPN and the CCPN and the Department.	X	
11.02	Submit authorization file to FI	X	
11.03	Maintain a provider database	X	
11.04	Maintain and develop an Enrollee website that includes enrollee materials, FAQs, QI meeting materials, Information on interpreter services, Information about QI initiatives, etc.	X	
11.05	Maintain secure website for PCP access	X	

Appendix DD

Attestation of Provider Network

(Company Letter Head)

Attestation of Provider Network Submission

For GSA _____ (A, B and/or C)

Date_____

I, _____, as (Title) for (Name of Company), do hereby attest that the information provided concerning our proposed network (letters of intent and/or subcontracts) is (are) accurate, true, and complete.

I attest that the necessary information for these providers will be loaded into our organization's system prior to providing services to Louisiana Medicaid/CHIP members. Additionally, I attest that the following requirements will be met:

- All subcontracts and amendments will utilize a model sub contract approved by DHH, or any modifications to the model subcontract have been approved by DHH prior to execution,
- All subcontracts will be properly signed, dated and executed by both parties, and
- All provider files will contain information regarding hospital privileges (if appropriate) and a list of group practice members.

In addition to the services provided through its subcontracted network, _____(CCN name) will provide access to enhanced primary care case management and PCP primary care management services consistent with the Contract with DHH.

I understand that should DHH determine at a later date that the submitted information is inaccurate, untrue, or incomplete, (Name of company) may be subject to sanctions and/or fines as outlined in the Contract with DHH.

_____ _____

Signature/Title Date

Appendix EE

DHH Person First Policy

POLICY NUMBER:	0004-03
SUBJECT:	Communications With Respect To Persons Served By DHH
CONTENT:	Use of respectful language when referring to individuals with disabilities who are served by the Department
EFFECTIVE DATE:	Issued: December 31, 2003
INQUIRIES:	Louisiana Department of Health and Hospitals Office of the Secretary 628 North 4th Street Baton Rouge, Louisiana 70802 Phone (225) 342-9500 FAX (225) 342-5568

COMMUNICATIONS WITH RESPECT TO PERSONS SERVED BY DHH

I. Purpose

This policy is to ensure that in all communications persons with disabilities who are served by the department are referred to in language that is affirmative and respectful.

The intent of this policy is to provide guidance to DHH employees and to provide a foundation for training, information and educational opportunities that produce changes in the language we use that ensures respect for the people we serve.

This policy shall not be used as the basis for any disciplinary action or discrimination against any employee who fails to adopt the elements of the policy described herein.

In addition, the policy is not intended to impede accurate communication about medical diagnoses, but rather, to affirm the dignity of people with disabilities and foster positive attitudes.

II. Applicability

This policy applies to all DHH employees.

III. Implementation

The effective date of this policy is December 31, 2003. Subsequent revisions shall become effective on the date the revisions are approved and signed by the Secretary.

IV. Policy

It is the policy of the Department of Health and Hospitals to use written and oral language that reflects the individuality and dignity of the persons we serve.

A. The Department recognizes that disability is a natural part of the human experience. It is, like gender and ethnicity, one of many characteristics of being human.

B. The Department acknowledges that words have power, the power to shape the way people think, feel, and act towards others. When a group of people wants understanding and acceptance, attention to the language used in talking and writing about them is particularly important.

C. Departmental employees have the opportunity to impact how people with disabilities are viewed, treated and responded to. The Department, therefore, adopts the use of positive language.

Such positive language refers to the person first, and then addresses traits or characteristics. It puts the person before the disability and describes what a person has, not what a person is. Positive language promotes understanding, respect, dignity and affirmative outlooks.

V. Guidelines for Using Positive Language

A. In preparing documents and presentations and in general oral conversations, each employee of the Department should consider the following:

1. The people we serve are first and foremost multi-dimensional human beings like everyone else but whom, secondarily, have a disorder with which they are dealing. A person does not equate to a disability, i.e., a person may have a condition like mental retardation, but would not be referred to as a mental retardate. Likewise, it is preferable to say that a person has a disability, rather than he is disabled. Phrases such as "developmentally disabled children:" should be replaced by "children with developmental disabilities."

2. Ask yourself whether it is necessary to mention disability in all cases. The term should be used only when it is significant to the conversation or understanding of written material.

3. Emphasis should to be placed on abilities, rather than limitations. Consider, for example, that wheelchairs allow people to be mobile, rather than being confined.

4. Avoid negative words or those that sensationalize disabilities. Words like "suffer", "tragedy", "problem" and "afflicted" are considered offensive.

5. "Problems" or "deficits" should be framed as needs. This is the traditional way that we refer to the supports we all need to operate, i.e., "I need glasses," rather than "I have a visual deficit."

6. Avoid euphemisms such as "differently-abled," and "special," when what is meant is segregated. The exception is where the term "special" is used as a part of a proper name as in "Special Olympics."

B. It is not the intent of this policy to impede communications in medical settings. Where the general population would be referred to as "clients," that same term is properly used in reference to persons with disabilities.

VI. Responsibility

It is the responsibility of each office/division/bureau to promote the use of positive language. The department recognizes, however, the changes demanded in this policy require a cultural shift that will not occur immediately, but over time and with support and training.

b. Each office/division/bureau is responsible for providing orientation, training, information and educational materials regarding the use of positive language to its employees.

c. Within each office/division/bureau, written materials, particularly those that will be shared with the public, are to be reviewed prior to distribution to ensure the use of respectful language. It is also important that positive language be used in individual planning documents and other materials written about specific individuals being served.

Notations:

A variety of resources were used in the preparation of this policy, including work by Kathie Snow at www.disabilityisnatural.com, the State of Texas Developmental Disabilities Council, Otto F. Wahl, Ph.D. at George Mason University, and the Nebraska Department of Health and Human Services.

Appendix FF

Provider Incentive Payments Template

Louisiana Coordinated Care Networks - Shared Provider Incentive Programs

Per Member Per Month Payments

Express all amounts on projected PMPM basis. Provide supporting documentation of how amounts were determined. Amounts should reflect only payments to non-related parties; i.e. exclude all payment variations in which the related party receives the variance.

		PMPM								
		Children and Families								
		Children (Ages 0-18)								
Service	*Description of payment methodology (attach additional detail as necessary)*	*Region 1*	*Region 2*	*Region 3*	*Region 4*	*Region 5*	*Region 6*	*Region 7*	*Region 8*	*Region 9*
Physician - Primary Care										
Physician - Specialty Care										
Hospital Inpatient - General										
Hospital Inpatient - Psychiatric										
Hospital Outpatient										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Total										
Projected enrollment										

		PMPM								
		Children and Families								
		Adults (Ages 19+)								
Service	*Description of payment methodology (attach additional detail as necessary)*	*Region 1*	*Region 2*	*Region 3*	*Region 4*	*Region 5*	*Region 6*	*Region 7*	*Region 8*	*Region 9*
Physician - Primary Care										
Physician - Specialty Care										
Hospital Inpatient - General										
Hospital Inpatient - Psychiatric										
Hospital Outpatient										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Total										
Projected enrollment										

Louisiana Coordinated Care Networks - Shared Provider Incentive Programs

Bonus Payments

Express all amounts on projected PMPM basis. Provide supporting documentation of how amounts were determined. Amounts should reflect only payments to non-related parties; i.e. exclude all payment variations in which the related party receives the variance.

		PMPM								
		Children and Families								
		Children (Ages 0-18)								
Service	*Description of payment methodology (attach additional detail as necessary)*	*Region 1*	*Region 2*	*Region 3*	*Region 4*	*Region 5*	*Region 6*	*Region 7*	*Region 8*	*Region 9*
Physician - Primary Care										
Physician - Specialty Care										
Hospital Inpatient - General										
Hospital Inpatient - Psychiatric										
Hospital Outpatient										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Total										
Projected enrollment										

		PMPM								
		Children and Families								
		Adults (Ages 19+)								
Service	*Description of payment methodology (attach additional detail as necessary)*	*Region 1*	*Region 2*	*Region 3*	*Region 4*	*Region 5*	*Region 6*	*Region 7*	*Region 8*	*Region 9*
Physician - Primary Care										
Physician - Specialty Care										
Hospital Inpatient - General										
Hospital Inpatient - Psychiatric										
Hospital Outpatient										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Total										
Projected enrollment										

Louisiana Coordinated Care Networks - Shared Provider Incentive Programs

Pay for Performance Incentive Payments

Express all amounts on projected PMPM basis. Provide supporting documentation of how amounts were determined. Amounts should reflect only payments to non-related parties; i.e. exclude all payment variations in which the related party receives the variance.

		PMPM								
		Children and Families								
		Children (Ages 0-18)								
Service	*Description of payment methodology (attach additional detail as necessary)*	*Region 1*	*Region 2*	*Region 3*	*Region 4*	*Region 5*	*Region 6*	*Region 7*	*Region 8*	*Region 9*
Physician - Primary Care										
Physician - Specialty Care										
Hospital Inpatient - General										
Hospital Inpatient - Psychiatric										
Hospital Outpatient										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Total										
Projected enrollment										

		PMPM								
		Children and Families								
		Adults (Ages 19+)								
Service	*Description of payment methodology (attach additional detail as necessary)*	*Region 1*	*Region 2*	*Region 3*	*Region 4*	*Region 5*	*Region 6*	*Region 7*	*Region 8*	*Region 9*
Physician - Primary Care										
Physician - Specialty Care										
Hospital Inpatient - General										
Hospital Inpatient - Psychiatric										
Hospital Outpatient										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Total										
Projected enrollment										

Louisiana Coordinated Care Networks - Shared Provider Incentive Programs

Other Payment Arrangements

Express all amounts on projected PMPM basis. Provide supporting documentation of how amounts were determined. Amounts should reflect only payments to non-related parties; i.e. exclude all payment variations in which the related party receives the variance.

		PMPM								
		Children and Families								
		Children (Ages 0-18)								
Service	*Description of payment methodology (attach additional detail as necessary)*	*Region 1*	*Region 2*	*Region 3*	*Region 4*	*Region 5*	*Region 6*	*Region 7*	*Region 8*	*Region 9*
Physician - Primary Care										
Physician - Specialty Care										
Hospital Inpatient - General										
Hospital Inpatient - Psychiatric										
Hospital Outpatient										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Total										
Projected enrollment										

		PMPM								
		Children and Families								
		Adults (Ages 19+)								
Service	*Description of payment methodology (attach additional detail as necessary)*	*Region 1*	*Region 2*	*Region 3*	*Region 4*	*Region 5*	*Region 6*	*Region 7*	*Region 8*	*Region 9*
Physician - Primary Care										
Physician - Specialty Care										
Hospital Inpatient - General										
Hospital Inpatient - Psychiatric										
Hospital Outpatient										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Total										
Projected enrollment										

Appendix GG

CCN Reference Questionnaire

RFP # 305PUR-DHHRFP-CCN-S-MVA

PROPOSAL REFERENCE QUESTIONNAIRE

REFERENCE SUBJECT: < ***INSERT NAME OF PROPOSER***>

The "reference subject" specified above, intends to submit a proposal to the Louisiana Department of Health & Hospitals (DHH) in response to the Request for Proposals (RFP) indicated for Medicaid managed care services. As a part of such proposal, the reference subject must include a number of completed and sealed reference questionnaires (using this form).

Each individual responding to this reference questionnaire is asked to follow these instructions:

- complete this questionnaire (either using the form provided or an exact duplicate of this document);
- sign and date the completed questionnaire;
- seal the completed, signed, and dated questionnaire in a new standard #10 envelope;
- sign in ink across the sealed portion of the envelope; and
- return the sealed envelope containing the completed questionnaire directly to the reference subject.

---

(1) What is the name of the individual, company, organization, or entity responding to this reference questionnaire?

(2) Please provide the following information about the individual completing this reference questionnaire on behalf of the above-named individual, company, organization, or entity.

NAME:	
TITLE:	
TELEPHONE #	
E-MAIL ADDRESS:	

(3) What services does /did the reference subject provide to your company or organization?

(4) What is the level of your overall satisfaction with the reference subject as a vendor of the services described above?

Please respond by circling the appropriate number on the scale below.

	1	2	3	4	5	
least satisfied						**most satisfied**

If you circled 3 or less above, what could the reference subject have done to improve that rating?

(5) If the services that the reference subject provided to your company or organization are completed, were the services completed in compliance with the terms of the contract, on time, and within budget? If not, please explain.

(6) If the reference subject is still providing services to your company or organization, are these services being provided in compliance with the terms of the contract, on time, and within budget? If not, please explain.

(7) How satisfied are you with the reference subject's ability to perform based on your expectations and according to the contractual arrangements?

(8) In what areas of service delivery does /did the reference subject excel?

(9) In what areas of service delivery does /did the reference subject fall short?

(10) What is the level of your satisfaction with the reference subject's project management structures, processes, and personel?

Please respond by circling the appropriate number on the scale below.

	1	2	3	4	5	
least satisfied						**most satisfied**

What, if any, comments do you have regarding the score selected above?

(11) Considering the staff assigned by the reference subject to deliver the services described in response to question 3 above, how satisfied are you with the technical abilities, professionalism, and interpersonal skills of the individuals assigned?

Please respond by circling the appropriate number on the scale below.

	1	2	3	4	5	
least satisfied						**most satisfied**

What, if any, comments do you have regarding the score selected above?

(12) Would you contract again with the reference subject for the same or similar services?

Please respond by circling the appropriate number on the scale below.

	1	2	3	4	5	
least satisfied						**most satisfied**

What, if any, comments do you have regarding the score selected above?

REFERENCE SIGNATURE:
(by the individual completing this request for reference information)

_____
(must be the same as the signature across the envelope seal)

DATE:

_____

Appendix HH

Instructions for Completing the Provider Incentive Payments Template

CCN-S Instructions for completing the Provider Incentive Payments Template for Provider Incentives and Enhanced Payments

The template (Appendix FF) is to be completed if the CCN would like for provider incentive payments and/or payments above the required Medicaid primary care physician (PCP) case management rates to be considered in the evaluation of its response. As such information may be considered proprietary or confidential, submission is voluntary, as all information included in the responses will be considered public. Respondents will not be penalized for failing to complete this section; however, they may earn extra credit if they do so.

Responses to this section will be evaluated based solely on the quantified payment amounts reported herein, based on projected utilization, and within the guidelines of the CCN program. Any health benefits or cost savings associated with any quality or incentive program should not be included in this section and will not be considered in the evaluation of this section; such benefits may be evaluated in §20 of the RFP.

This section of the RFP seeks information on all circumstances where you propose any additional payment mechanism. If you are a selected vendor, your answers to this section will become part of your contract with DHH and DHH will confirm your compliance. The incentives and payments proposed herein may be revised downward during the term of your contract only with the written approval of DHH; as such programs were considered in the evaluation of the response. Increases in payments during the term of the contract may be implemented without such approval.

For such payments to be considered in the evaluation, they must be the minimum payment rates associated with the plan's operating policies and not negotiated rates for a subset of the providers. As an example, if the plan's physician payment policy includes an additional case management payment, then the difference between the minimum Medicaid PCP payment and the additional amount would be the quantifiable variance to be reported in this section; if the Medicaid PCP payment was the base rate and anything above that amount subject to negotiation, then such amounts would not qualify for inclusion herein.

If you propose to contract with any providers using methodologies or rates that differ from the applicable Medicaid requirement, include such arrangements. By provider type, describe the proposed payment methodologies/rates and quantify the projected per member per month benefit as requested in the attached.

PCP case management fee payments based on projected utilization would be removed in the determination of the enhanced value.

Do not include payments for services where Federal or State requirements are currently scheduled to increase payments at a future date. In such circumstances, maintenance of effort will be expected of the CCN.

During the evaluation of the proposals, preferences will be given to plans based upon the cumulative amount of quantified provider benefit associated with the following:

- bonus payments
- pay for performance incentive payments
- other payment arrangements

Payments for case management services may be included if paid to unrelated practitioners, e.g., physicians, clinics, etc. Do not include any primary care case management payment meeting the requirements of Section § 4.2 of the Request for Proposals, e.g., those amounts required to be paid to primary care physicians. Amounts greater than the required PCP amounts, may be included.

For bonus pools or Pay for Performance (P4P) programs, describe the eligible categories of provider, the basis for paying the applicable bonus pools and the proposed terms and conditions in the template. You may attach additional information, as appropriate. If such payments are contingent upon any shared savings calculation, include all assumptions pertaining to how such savings were estimated.

Indicate if any bonus pool is to be held in escrow, and if so who will be the escrow agent.

The attached template and all additional documentation and calculations should be accompanied by a statement from the preparing/consulting actuary certifying the accuracy of the information.

Appendix II

OPH/CCN Memorandum of Understanding

Office of Public Health Memorandum of Understanding Guidelines

The CCN will coordinate its public health-related activities with the Louisiana Office of Public Health (OPH). Coordination mechanisms and operational protocols for addressing public health issues will be negotiated with OPH and BHSF (Medicaid) and reflect Louisiana public health priorities. The coordination of activities related to public health will take the form of agreements among the parties which may include policy memos or separate memorandums of understanding signed by OPH, BHSF (Medicaid), and the CCNs. Public health-related activities include, but are not limited to:

- Sexually transmitted diseases
- Human immunodeficiency virus (HIV/AIDS) prevention and treatment
- Tuberculosis
- Immunization
- WIC (Supplemental Nutrition Program for Women, Infants, and Children)
- Family planning
- Maternal and child health (MCH)
- Children's Special Health Services (Louisiana's program for children with special health care needs)
- Population-based services

MOU's will cover the following topics with regard to the public health activities:

- Statement of common goals, priority populations and conditions and measurable objectives
- Inter-organizational communication protocols
- Data sharing and reporting
- Coordination of outreach and education
- Population health assessments
- Case management for high-risk populations (TB, HIV/AIDS, STD, NFP)
- Technical assistance
- Special projects (e.g., mutual pursuit of grants)
- Attachment: List of public health resources in region and identification of those that are "in network"

Appendix JJ

Turnover Plan

TURNOVER REQUIREMENTS

Introduction

Turnover is defined as those activities that the CCN is required to perform upon termination of the Contract in situations in which the CCN must transition contract operations to DHH or a third party. The turnover requirements in this Section are applicable upon any termination of the Contract 1) initiated by the CCN, 2) initiated by DHH, or 3) at the expiration of the contract period and any extensions.

General Turnover Requirements

In the event the Contract is terminated for any reason, the CCN shall:

- Comply with all terms and conditions stipulated in the Contract, including continuation of core benefits and services under the Contract, until the termination effective date;

- Promptly supply all information necessary for the reimbursement of any outstanding claims; and

- Comply with direction provided by DHH to assist in the orderly transition of equipment, services, software, leases, etc. to DHH or a third party designated by DHH.

Turnover Plan

- In the event of written notification of termination of the Contract by either party, the CCN shall submit a Turnover Plan within thirty (30) calendar days from the date of notification, unless other appropriate timeframes have been mutually agreed upon by both the CCN and DHH. The Plan shall address the turnover of records and information maintained by the CCN relative to core benefits and services provided to Medicaid members. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan must be approved by DHH.

- If the Contract is not terminated by written notification as provided above, the CCN shall propose a Turnover Plan six months prior to the end of the contract period, including any extensions to such period. The Plan shall address the possible turnover of the records and information maintained to either DHH or a third party designated by DHH. The Turnover Plan must be

a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan must be approved by DHH.

- As part of the Turnover Plan, the CCN must provide DHH with copies of all relevant member and core benefits and services data, documentation, or other pertinent information necessary, as determined by DHH, for DHH or a subsequent CCN to assume the operational activities successfully. This includes correspondence, documentation of ongoing outstanding issues, and other operations support documentation. The Plan will describe the CCN's approach and schedule for transfer of all data and operational support information, as applicable. The information must be supplied in media and format specified by DHH and according to the schedule approved by DHH.

Transfer of Data

The CCN shall transfer all data regarding the provision of member core benefits and services to DHH or a third party, at the sole discretion of DHH and as directed by DHH. All transferred data must be compliant with HIPAA.

All relevant data must be received and verified by DHH or the subsequent CCN. If DHH determines that not all of the data regarding the provision of member core benefits and services to members was transferred to DHH or the subsequent CCN, as required, or the data is not HIPAA compliant, DHH reserves the right to hire an independent contractor to assist DHH in obtaining and transferring all the required data and to ensure that all the data are HIPAA compliant. The reasonable cost of providing these services will be the responsibility of the CCN.

Post-Turnover Services

Thirty (30) days following turnover of operations, the CCN must provide DHH with a Turnover Results report documenting the completion and results of each step of the Turnover Plan. Turnover will not be considered complete until this document is approved by DHH.

If the CCN does not provide the required relevant data and reference tables, documentation, or other pertinent information necessary for DHH or the subsequent CCN to assume the operational activities successfully, the CCN agrees to reimburse DHH for all reasonable costs, including, but not limited to, transportation, lodging, and subsistence for all state and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, reproduction and transfer functions at the location(s) of such records.

The CCN also must pay any and all additional costs incurred by DHH that are the result of the CCN's failure to provide the requested records, data or documentation within the time frames agreed to in the Turnover Plan.

The CCN must maintain all files and records related to members and providers for five years after the date of final payment under the Contract or until the resolution of all litigation, claims, financial management review or audit pertaining to the Contract, whichever is longer. The CCN agrees to repay any valid, undisputed audit exceptions taken by DHH in any audit of the Contract.

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Appendix KK

DHH Policy on Criminal History Records Check for Applicants and Employees

POLICY NUMBER: 8133-98

SUBJECT: Criminal History Records Check of Applicants and Employees

CONTENT: Procedures for obtaining criminal background checks of employees and contract staff who have supervisory or disciplinary authority over children and staff who have access to Electronic Protected Health Information (e-PHI) on a daily basis.

EFFECTIVE DATE: Issued: August 31, 1998
Revised: September 8, 2010

INQUIRIES TO: Bureau of Health Services Financing
Medicaid Management Information System
628 North 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030
(225)342-3855; FAX: (225)342-2703

Office of Management and Finance
Division of Human Resources, Training & Staff Development
628 North 4th Street
P. O. Box 4818
Baton Rouge, LA 70821-4818
(225)342-6477; FAX: (225)342-6892

CRIMINAL RECORDS CHECKS

I. POLICY STATEMENT

The intent of this policy is to require criminal records checks on Department of Health and Hospitals (DHH) employees, contractors and volunteers who (1) have supervisory or disciplinary authority over children, and/or (2) have access to Medicaid recipients' and applicants' Electronic Protected Health Information (e-PHI) in order to accomplish their assigned job duties. Appointing authorities may choose to conduct criminal records checks on other employees based on programmatic need. Each DHH office affected by this policy must develop and implement a procedure to assure compliance.

II. APPLICABILITY

This policy is applicable to all DHH employees, volunteers and contractors who meet the criteria set forth in this policy.

III. EFFECTIVE DATE

The effective date of this revised policy is September 8, 2010.

IV. POLICY PROVISIONS

Note: Section IV. A. applies only to individuals who have supervisory or disciplinary authority over children. Section IV. B. applies only to individuals who have access to Electronic Protected Health Information.

A. SUPERVISORY OR DISCIPLINARY AUTHORITY OVER CHILDREN

In accordance with the Louisiana Child Protection Act, R. S. 15:587.1, all employees who were hired after September 1987 and all new hires having responsibility for the care, control, supervision and/or discipline of individuals up to age 18 must have criminal history inquiries made to ascertain that the persons have/have not been arrested for, convicted of or pled "nolo contendere" to any one or more of the crimes that are listed in R. S. 15:587.1 as of the effective date of this policy and including any amendments made to R. S. 15:587.1 hereafter. Background checks must also include inquiries regarding arrest or conviction for attempt or conspiracy to commit any of those offenses. (See Part IV. A.1 of this policy for statutory citations enumerated in R. S. 15:587.1 as of the effective date of this policy).

1. Statutory citations enumerated in R. S. 15:587.1 as of the effective date of this policy are as follows:

   R. S. 14:30

R. S. 14:30.1
R. S. 14.31
R. S. 14.41 through R. S. 14:45
R. S. 14:74
R. S. 14.78
R. S. 14.79.1
R. S. 14:80 through R. S. 14:86
R. S. 14.89
R. S. 14.89.1
R. S. 14:92
R. S. 14:93
R. S. 14:93.2.1
R. S. 14:93.3
Crimes of violence as defined in R. S. 14:2(B)
Sex offenses as defined in R. S. 15:541
R. S. 14:106
R. S. 14:282
R. S. 14:283.1
R. S. 14:284
R. S. 14:286
R. S. 40.966 (A)
R. S. 40.967 (A)
R. S. 40.968 (A)
R. S. 40.969 (A)
R. S. 40:970 (A)

2. According to the Louisiana Child Protection Act (R. S. 15:587.1) any person being considered for a position having supervisory or disciplinary authority over children and who has been convicted of or has pled "nolo contendre" to one or more of the crimes cited in R. S. 15:587.1, or has been convicted of attempt or conspiracy to commit any of these offenses, shall not be hired in that position. If an offer has already been extended or employment has commenced, the offer shall be rescinded or the appointment terminated. Before taking such action the appointing authority shall consult with legal and human resources staffs to assure compliance with all applicable rules and regulations. All appointments shall be on a probationary status until the criminal background check is complete.

B. ACCESS TO MEDICAID RECIPIENTS' ELECTRONIC PROTECTED HEALTH INFORMATION (E-PHI)

All new hires and current DHH employees whose duties require access to e-PHI must have criminal background checks to safeguard the privacy of Medicaid recipients' and applicants' e-PHI.

1. If an individual currently in an affected position or being considered for an affected position (by original appointment, promotion, transfer, detail, demotion, reassignment or other personnel action) has been convicted of or has pled "nolo contendere" to any felony in Louisiana or any crime of a jurisdiction other than Louisiana which would constitute a misdemeanor or felony under Louisiana law, the appointing authority shall determine the action to be taken. The appointing authority shall consult with human resources and legal staffs in making these determinations. All appointments shall be on a probationary status until the criminal background check is complete.

2. Each employee whose job duties require access to e-PHI shall have a criminal background check conducted on him five years from the date of the original criminal background check and every five years thereafter.

V. RECOMMENDED PROCEDURE

A. Procedure for Acquiring Criminal History Background Checks

The following procedure is recommended in acquiring criminal history background checks:

1. The agency completes the Authorization to Disclose Criminal History Records Information form (See Appendix A) on each employee/applicant requiring a criminal background check. If any assistance is required in completing the form, the Bureau of Criminal Identification may be contacted at the address below:

   Louisiana State Police
   Bureau of Criminal Identification
   P. O. Box 66614
   Baton Rouge, Louisiana 70896-6614
   Telephone: (225) 925-1886

2. Completed forms are sent to the Bureau of Criminal Identification along with an interagency billing form PV2 (Attachment B) that includes the following information:

   a. agency name and number;
   b. agency GFS number; and,
   c. object number.

<u>Employees are not to be charged for the cost of the records check.</u>

3. The Bureau of Criminal Identification will conduct a search against existing criminal records on each employee/applicant and a report will be submitted to the agency on each employee/applicant. The report will indicate if no record is found or if a record of felony conviction is found.

   Initially, the background check consists of a name check only. If further clarification of identity is needed, the Bureau of Criminal Identification will contact the agency for the employee/applicant's fingerprints.

4. All information received from the Bureau of Criminal Identification should be:

   a. filed in a secure place;
   b. maintained as evidence of termination for cause;
   c. not released to any source other than upon court or Civil Service Commission order; and,
   d. destroyed three years after an employee leaves the agency.

5. Access to the reports of an applicable employee shall be limited to the agency's appointing authority and the Human Resources and Legal offices.

ATTACHMENT A

TO: Louisiana State Police
Bureau of Criminal Identification
P. 0. Box 66614
Baton Rouge, Louisiana 70896

FROM: _____
REQUESTING NAME OF FACILITY/AGENCY/ETC. (PLEASE PRINT)

_____
MAILING ADDRESS, CITY, STATE, ZIP

_____
FACILITY ADMINISTRATOR **FACILITY PHONE #**

RE: Authorization to Disclose Criminal History Records Information

As an employee of the above-listed facility or agency, I understand a thorough investigation of any record of past criminal activities will be conducted by the Louisiana Department of Public Safety and Corrections, Office of State Police.

By my signature below, I hereby authorize such an investigation and further authorize the Louisiana State Police to release all criminal record information maintained in their files which may confirm or deny my eligibility for employment to the facility or agency named above.

FULL NAME (Printed) _____

SIGNATURE: _____

SOCIAL SECURITY #_____**DATE OF BIRTH**_____

DRIVER'S LICENSE #_____

RACE/SEX _____

DATE_____ **WITNESS**_____

PLEASE CHECK ONE:

WORKING WITH CHILDREN_____ **HEALTH CARE PROVIDER**_____

OTHER_____

ATTACHMENT B

PURCHASER: _____

_____

_____

TO: Louisiana State Police
Bureau of Criminal Identification
P.O. Box 66614
Baton Rouge, La. 70896-6614

DESCRIPTION OF GOODS/SERVICES:

PLEASE USE THE FOLLOWING EXPENDITURE CODING TO PROCESS THE INTERAGENCY TRANSACTION (GFSJ4/PV TYPE 2)

AGENCY NAME & NUMBER	GFS NUMBER	OBJECT NUMBER	COST

PREPARER: _____

APPROVED: _____ **DATE:** _____

Appendix LL

Data Use Agreement between Louisiana Department of Health and Hospitals And Coordinated Care Network (CCN) Proposer

Data Use Agreement Between Louisiana Department of Health and Hospitals And Coordinated Care Network (CCN) Proposer

This Data Use Agreement for a Limited Data Set is entered into by and between the following parties and shall become effective immediately upon being signed by both parties:

> **Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF),** hereinafter referred to as "DHH" or "Data Owner"; and_____, potential proposer, hereinafter referred to as "Data User."

Purpose of Agreement:

DHH, through its Bureau of Health Services Financing (BHSF), administers the Louisiana Medicaid program. BHSF, as the Data Owner, has issued a Request for Proposals (RFP) for the operation of its new Coordinated Care Network (CCN) program, and the Data User will submit a proposal to DHH in response to that RFP. The Data User will analyze all Medicaid claims data solely at its own expense and at no cost to DHH. DHH will provide the Data User with the specific Limited Data Set information described below.

Obligations of Data Owner:

DHH, as the Data Owner, agrees to provide the following described information to the Data User. The Limited Data Set below, as defined in the HIPAA Privacy Rule, to the Data User constitutes:
Twenty-four (24) months of claims and eligibility data to include July 1, 2008 – June 30, 2010 with the inclusion of select denied claims for service limitations and the exclusion of pending claims. Protected Health Information (PHI) will be excluded. The following files will be included:

a. Professional and institutional claims (Claims_FY09_CCN.sas7bdat and Claims_FY10_CCN.sas7bdat)
b. Pharmacy claims (Rx_FY09_CCN.sas7bdat and Rx_FY10_CCN.sas7bdat)
c. Eligibility data (Eligibility_CCN_FY09.sas7bdat and Eligibility_CCN_FY10.sas7bdat)
d. Deliveries data (Deliveries_CCN.sas7bdat)
e. Outliers data (Outliers_CCN.sas7bdat)

LA Contents_CCN_0405

MVA's point of contact regarding this data set will be Steve Annison of the Medicaid Coordinated Care Section (Steve.Annison@LA.GOV). All data will be used for business nature only.

Obligations of Data User:

The Data User shall limit access to Limited Data Set information strictly to those individuals or classes of individuals who shall have access in order to perform their duties in connection with

the below described purposes related to the Louisiana Coordinated Care Network RFP, which is part of the health care operations of Louisiana Medicaid.

a. *Uses and Disclosures as Requested in this Agreement*. With sole regard to this RFP the Data User shall use and disclose the Limited Data Set information provided by the Data Owner only for the following purposes directly related to development of proposals for this RFP:

   Analysis for preparation of CCN proposal

b. *Nondisclosure except as Provided in this Agreement*. The Data User shall not use or further disclose the Limited Data Set information except as specified in this Agreement.

c. *Follow-Back*. The Data User shall not contact the subjects of the information, the subjects' next-of-kin, the subjects' physicians or other providers, or any other relative or interested party.

d. *Safeguards*. The Data User agrees to take appropriate administrative, technical and physical safeguards to protect the Limited Data Set information from any unauthorized use or disclosure not provided for in this Agreement. The Data Owner shall ensure that no identifying information is transmitted through unsecured telecommunications, including unsecured Internet connections.

e. *Reporting*. Within 48 hours of the Data User's discovery, the Data User shall report to the Data Owner any use or disclosure of the Limited Data Set information that violates either this Agreement or applicable state or federal laws or regulations.

f. *Public Release*. No Limited Data Set information or analysis of information shall be publicly released.

g. *Breach of Agreement by Data User*. In the event that the Data User breaches this Agreement, the Data Owner, at its sole discretion, may: (1) terminate this Agreement upon written notice to the Data User, or (2) request that the Data User, to the satisfaction of the Data Owner, take appropriate steps to cure such breach. If the Data User fails to cure such breach to the Data Owner's satisfaction or in the time prescribed by the Data Owner, the Data Owner may terminate this Agreement and/or disqualify the Data User as a CCN proposer upon written notice to the Data User.

h. *Termination of Agreement and Destruction of Records*. This Agreement shall terminate upon any of the following events, whichever occurs first: (1) termination by the Data Owner as provided in paragraph (g); (2) termination by either party for any reason upon giving five (5) days' written notice to the other party; (3) the completion of Data User's analysis and the submission of its proposal to the Data Owner; or (4) the date of deadline for submission of proposal. Immediately upon termination of this Agreement, the Data User shall destroy all Limited Data Set information provided to it by the Data Owner.

i. *Minimum Necessary*. The Data User attests that the Limited Data Set information requested represents the minimum information necessary for the Data User to perform the tasks called for in this Agreement, and that only the minimum necessary individuals shall have access to the information in order to perform such tasks.

j. *Data Ownership*. DHH is the Data Owner. The Data User does not obtain any right, title or interest in any of the data furnished by DHH.

By signing this Agreement, the authorized representatives of DHH and the Data User agree to all of its provisions.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement as of the date(s) written below.

Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF)

By: _____ _____

Don Gregory, Medicaid Director, DHH/BHSF Date
(225) 342-3891
Don.Gregory@LA.GOV

_____

Printed Name of Data User (Proposer) Company

By: _____ _____

Signature of Data User (Proposer) Representative Date

_____

Printed Name of Data User (Proposer) Representative