
# Office of State Procurement
# PROACT Contract Certification of Approval

## This certificate serves as confirmation that the Office of State Procurement has reviewed and approved the contract referenced below.

**Reference Number:** 2000106502 ( 3)
**Vendor:** Maximus Health Services
**Description:** Serves as enrollment broker for Medicaid managed care program
**Approved By:** Pamela Rice
**Approval Date:** 1/25/2016

Your amendment that was submitted to OSP has been approved.

Rev 2010/08

LaGov #2000106502

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

DEPARTMENT OF HEALTH AND HOSPITALS

Medical Vendor Administration

(Regional/ Program/ Facility)

AND

MAXIMUS Health Services, Inc.

Contractor Name

Amendment #: 3

CFMS #: 708339

DOA #: 305-200574

DHH #: 057770

Original Contract Amt $11,888,545.00

Original Contract Begin Date 11-01-2011

Original Contract End Date 10-31-2014

## AMENDMENT PROVISIONS

Change Contract From: Maximum Amount: $19,385,285.00

CF-1 Block 13 Maximum Contract Amount $19,385,285 FY12 $3,407,809, FY13 $4,361,976, FY14 $3,558,603, FY15 $3,500,519, FY16 $3,425,856, FY17 $1,130,522

CF-1 Block 14 - see changes attached as Addendum 1

Statement of Work - see changes attached

Change To: Maximum Amount: $27,542,147.00

CF-1 Block 13 Maximum Contract Amount FY12 $3,407,809, FY13 $4,361,976, FY14 $3,558,603, FY15 $3,500,519, FY16 $9,234,950, FY17 $3,478,290

CF-1 Block 14 - see changes attached as Addendum 1

Statement of Work - see changes attached

Justification:

Due to the new financial eligibility methodology required by the federal Affordable Care Act, the contractor will provide outreach to those individuals applying for Medicaid or reaching their annual redetermination date. A significant portion of citizens lacks ready access to a computer or Medicaid eligibility office, and a large volume of existing cases will require contact to obtain data required by the ACA, so the contractor will handle requests to complete applications and renewals for Louisiana Medicaid by telephone. The contractor will also enter the information in the state's online application system.

This Amendment Becomes Effective: 08-01-2015

This amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this amendment is signed and entered into on the date indicated below.

**CONTRACTOR**

MAXIMUS Health Services, Inc.

CONTRACTOR SIGNATURE [signature] DATE 11/23/15

PRINT NAME: Adam Polatnick

CONTRACTOR TITLE: Vice President, Contracts

**STATE OF LOUISIANA**
**DEPARTMENT OF HEALTH AND HOSPITALS**

**Secretary, Department of Health and Hospital or Designee**

SIGNATURE [signature] 11-30-15 DATE

NAME: W. Jeff Reynolds

TITLE: Undersecretary

OFFICE: Bureau of Health Services Financing

PROGRAM SIGNATURE DATE

NAME

**CF-6 Addendum 1**

**Changes to CF-1 Block 14 (Changes in bold)**

**Change FROM:**
The Contractor shall submit a monthly invoice no later than 15 days following the month of services for the total number of members included on the full X12 834 Member Enrollment File sent to the Medicaid Fiscal Intermediary, CCN activities and GNOCHC activities shall be shown separately, Payment will be determined by the number of members times the Per Member Per Month (PMPM) amount. The monthly invoice shall also include the cost of postage, specifically listing whether the mail was bundled, the postage rate, the class of mail and the item count statistics on the invoice. For Add'l Terms of Payment, See Attachment 3. Within ten (10) days of the signing of the contract. The Contractor shall procure, submit and maintain a Performance Bond in the amount of ten (10) percent of the annual contract amount and be renewable annually. The bond will be released at the end of contract.

**Change TO:**
The Contractor shall submit a monthly invoice no later than 15 days following the month of services for the total number of members included on the full X12 834 Member Enrollment File sent to the Medicaid Fiscal Intermediary, **Payment for MCO activities and call assistance activities will be calculated by multiplying the total number of members by the Per Member Per Month (PMPM) rate of $0.72. Should the total number of members reach 1,250,000, the PMPM rate shall increase by $0.02 for each member above the 1,250,000 threshold. Any price adjustment shall be effective immediately and shall be applied to that month's invoice**. The monthly invoice shall also include the cost of postage, specifically listing whether the mail was bundled, the postage rate, the class of mail and the item count statistics on the invoice. For Additional Terms of Payment, See Attachment 3. Within ten (10) days of the signing of the contract, the Contractor shall procure, submit and maintain a Performance Bond in the amount of ten (10) percent of the annual contract amount and be renewable annually. The bond will be released at the end of contract.

**Statement of Work**

MAXIMUS Health Services, Inc

**Goal/Purpose**

To provide support services and further the general welfare of Louisiana Medicaid eligible citizens through choice counseling, enrollment, and disenrollment into Medicaid's ~~Coordinated Care Network (CCN)~~ managed care ~~P~~**p**rogram, consistent with federal Medicaid and state requirements.

**Deliverables**

The Contractor shall provide all deliverables required in the Request for Proposals issued April 29, 2011 (which includes subsequent written responses to written comments and all Addendums) within the specified timeframes. The Contractor shall provide deliverables included in the Contractor's Technical Proposal received on June 17, 2011, by the dates specified in the proposal.

DHH accepts the schedule for deliverables and recommended timeframes as provided in the "Work Plan" included in the Contractor's Technical Proposal. With the prior written approval of DHH, the time frames may be adjusted based on the implementation status and revisions to timelines for other DHH ~~CCN~~ **managed care**-related contracts.

The major deliverables include, but are not limited, to the following:

1. **Enrollment of Medicaid Recipients into Managed Care**
   The Contractor shall be prepared to assist all Louisiana Medicaid and CHIP mandatory and voluntary managed care enrollees in initially enrolling into a Medicaid managed care program no later than November 1, 2011.

   The Contractor will inform all Medicaid and CHIP potential enrollees of **all managed care organization (MCO) options.** ~~managed care options available in their geographic service area (GSA)~~. The Contractor shall ensure that, before enrolling, the potential enrollee has information he or she needs to make an informed decision. This information shall be provided in an objective, non-biased fashion that neither favors nor discriminates against any managed care provider.

   ~~The Contractor shall provide and mail an enrollment packet to all new CCN eligibles within the timeframes specified in the RFP. The enrollment packet will include a flyer or brochure, which will be provided to the Contractor by each CCN in the Geographic Service Area (GSA), a Welcome Letter, a detailed comparison sheet outlining the unique features of each CCN in the GSA, an Enrollment Form, and a business reply envelope~~

   **Effective 2/1/2015 Medicaid applicants will have, at the time of application, the ability to select an MCO. The applicants whose financial eligibility determination is certified by DHH to be Medicaid eligible, will be processed and forwarded to the Fiscal Intermediary (FI). The FI will transmit the member to the Contractor. Those applicants who pro-actively selected an MCO will be auto assigned to the MCO selected unless the MCO is unavailable. The Medicaid eligibles who did not select MCO at the time of application will be auto-assigned to an MCO utilizing the Auto-Assignment Algorithm approved by DHH.**

   The Contractor shall generate a Confirmation Letter indicating the name of the ~~CCN~~ **MCO** to which enrollees are assigned within two (2) business days of receipt. **The confirmation letter will inform the member of their options to change MCOs and the limitations for requesting a change. The confirmation letter will also include a detailed comparison chart outlining the unique features of each MCO.** ~~of the 834 file if it includes a CCN indicator, or the date of receipt of pro-active selection, or the date of automatic assignment, whichever is applicable. During the transition of existing members to CCNs, the letter shall be mailed within five (5) business days. After the transition of existing members is complete the letter shall be mailed within two (2) business days.~~

   The Contractor shall offer multilingual enrollment materials and materials in alternative format such as large print, and/or Braille when requested.

The Contractor shall offer multiple approaches to ~~CCN~~ **MCO** enrollment. The Contractor must support the following methods of enrollment:

a) Enrollment by mail with inclusion of postage paid return envelope;

b) Web based enrollment;

c) Telephone enrollment via a toll-free number;

d) ~~Face-to-face enrollment assistance, if such assistance is specifically requested by the potential enrollee or enrollee~~; and

e) Smart phone or tablet device capabilities (may be limited number of applications).

~~The Contractor shall accept eligibility files identifying CCN eligibles from the Medicaid Fiscal Intermediary and generate a mail file for mailing of the Enrollment Packet (see above) within two (2) business days of receiving the eligibility file. The Welcome Letter must clearly state the deadline to enroll. If the enrollment file contains the name of a preferred CCN, or the enrollee contacts the Contractor and chooses a CCN prior to receipt of the Enrollment File, mailing the Welcome Packet is not required.~~

~~The Contractor shall identify Enrollment Forms received from potential CCN enrollees that cannot be processed due to incomplete information or illegible information the same day forms are received or no later than the next business day, and generate a mail file for mailing of the Missing Information (MI) letter. The Contractor shall first attempt to contact the potential enrollee by phone to obtain missing information and if the Contractor is unable to reach the potential enrollee by phone, missing enrollment information shall be requested by mail.~~

The Contractor shall request verification of federal tribe affiliation for any member who requests to opt out from the ~~CCN~~ **MCO** Program on the basis of Native American or Alaskan Native status.

~~**2. Promoting Pro-active Choice of CCN MCO**~~

~~The Contractor shall implement operational procedures and provide written materials to all Medicaid and CHIP CCN enrollees that are designed to encourage potential enrollees to proactively select a CCN, rather than be automatically assigned, to achieve a pro-active choice percentage of 51% or greater.~~

~~The Contractor shall, beginning January 2012 and quarterly thereafter, survey 20% of **new** CCN **MCO** eligibles who failed to choose a managed care entity to determine the reason a pro-active selection was not made and submit a report to DHH including the name of enrollee, Medicaid ID #, effective date of CCN **MCO** enrollment and reason given for not pro-actively selecting a CCN **MCO**.~~

**2. ~~3.~~ Systems**

The Contractor shall provide the systems necessary to successfully exchange files with the Medicaid Fiscal Intermediary Contractor and ~~CCN~~ **MCO**s, including but not limited to membership files and network provider listings.

The Contractor shall provide the computer and networking equipment required to exchange data as specified by the Medicaid Fiscal Intermediary and approved by DHH.

**See Section §9 of the Request for Proposals for the comprehensive list of system related deliverables.**

**3. ~~4.~~ Enrollee Call Center**

The Contractor shall establish a “user friendly” toll-free telephone line for Members, Potential Members and their caregivers that is staffed at a level sufficient to answer ninety-five percent (95%) of calls received from 8:00 a.m. – 5:00 p.m (Central Standard Time) Monday through Friday, excluding state holidays to ensure no more than a two (2) minute wait time for callers. After a two (2) minute wait, calls must be rolled over to an automatic attendant for messaging.

An automated phone system must be maintained for telephone calls received after hours with response to messages occurring the next business day.

**Refer to Section §4.4.6 of Request for Proposals for additional Call Center Requirements**

4. ~~**5.**~~ **Annual Open Enrollment**
   The Contractor shall inform every ~~CCN~~ **MC**O member in writing that they may select a different ~~CCN~~ **MCO** no less frequently than twelve months after initial enrollment or last reenrollment in the ~~CCN~~ **MCO**. The Contractor shall design and submit for DHH approval by April 1, 2012, a methodology for conducting required annual Open Enrollment. ~~that allows for an even flow of enrollees throughout the year.~~

5. ~~**6.**~~ **Processing Disenrollment Requests**
   The Contractor shall receive and timely process requests for disenrollment of members from ~~CCN~~ **MCOs** which may be initiated by either the ~~CCN~~ **MCO** or the member. The Contractor shall investigate and determine if requests for member disenrollment meet the For Cause criteria as specified in the Request for Proposals. The Contractor shall develop written criteria for Disenrollment Request resolutions that do and do not require prior DHH approval and submit to DHH for approval by January 1, 2012.

~~**6. CCN Administrative Performance Measure Verification Calls**~~
~~The Contractor shall perform a monthly random telephone sample beginning January 2012, of 20 unduplicated PCP practices within each CCN network to determine whether the DHH 24/7 phone access requirement requiring a PCP practice clinician be available to speak with a member within 30 minutes of member's initial contact is met. The Contractor shall submit a quarterly report beginning May 2012 that details findings for the previous three (3) months and an annual summation report for each CCN beginning in January 2013.~~

6. ~~**8.**~~ **Reporting to DHH**
   The Contractor shall provide timely and accurate reports to DHH in formats and timeframes as specified in the RFP. For specifics see Section § 5.1.1.3 -5.1.1.9.

7. ~~**9.**~~ **Complaint Tracking and Reporting**
   By November, 1, 2011, the Contractor will development and implement a web-based Master Member and Provider Complaint Tracking System for ~~the~~ **Medicaid Managed Care** ~~Medicaid Coordinated Care Section (MCCS)~~ which can be utilized via secure access by DHH staff and/or and other parties designated by DHH**.** ~~such as the CCN Consumer Ombudsman by November 1, 2011.~~

   The system shall maintain a record of complaints, investigation efforts, and resolution, including whether the complaint is justified and contain an indicator for who input the complaint into the system. The Contractor shall propose written criteria to DHH for what constitutes a justified complaint and a classification system for level of severity of complaints by October 1, 2011.

   The Contractor shall accept member complaints, investigate complaints, determine if the complaint is justified and document complaint investigation activities for all complaints made directly to the Contractor.

   The Contractor shall provider a monthly Master Complaint Tracking Report to DHH beginning December 2011 for activity in November 2011.

8. ~~**10.**~~ **Member Related Materials**
   All member-related materials shall adhere to the requirements in the RFP

9. ~~**11.**~~ **Build and Maintain ~~CCN~~ MCO Enrollment Website**
   The Contractor shall develop, implement by November 1, 2011, and provide ongoing maintenance for the official website for the Louisiana Medicaid ~~CCN~~ **MCO** Program. **Refer to RFP for specifics.**

10. **Application and Renewal Assistance**

**Due to the new financial eligibility methodology required by the federal Affordable Care Act, the contractor will provide assistance to those individuals applying for Medicaid or reaching their**

**annual redetermination date. A significant portion of citizens lacks ready access to a computer or Medicaid eligibility office, and a large volume of existing cases will require contact to obtain data required by the ACA, so the MAXIMUS call agents will assist callers in completing Medicaid financial applications for assistance and renewals using the state's online application system. Call center agents will manually enter all applicant information into the DHH online application system.**

**Call center agents will be required to handle various calls received from individuals and households identified by DHH who need assistance completing forms and applications pertaining to their Medicaid eligibility, including but not limited to:**

- **Renewal Medicaid Applications**
- **New Medicaid Applications**
- **1095-B IRS Forms**
- **Other Call Types as mutually agreed upon**

a. **Renewal Assistance Calls**
   **Calls received from individuals and households identified by DHH who need assistance in completing the online Medicaid financial application in order to renew their Medicaid coverage. Information collected from the call will include demographic information, such as residency, income, and household composition. These calls will be received on a toll free line established by the contractor, dedicated for application and renewal assistance calls.**

b. **New Applicant Assistance Calls**
   **Calls received from individuals and households who need assistance in completing the online Medicaid application to determine eligibility for Medicaid coverage. Information collected from the call will include demographic information, such as residency, income, and household composition. These calls will either be transferred by DHH or received directly by callers via a separate toll free line established by the contractor dedicated for application and renewal assistance calls.**

c. **Referrals and Transferred Calls from DHH**
   **Calls received as a result of a transfer or referral by DHH to assist callers with information pertaining to:**

   - **Questions or inquiries about Medicaid eligibility**
   - **Questions or inquiries about applying for Medicaid**
   - **Updating or changing address information**

d. **Other Call Types**
   **Other types of calls mutually agreed upon by DHH and the Contractor**

**PERFORMANCE MEASURES**

The Contractor shall provide to DHH or maintain the following to document deliverables:

**1. Enrollment of Medicaid Recipients into ~~CCN~~ MCOs**

- ~~Submit Draft Enrollment Packet (Welcome Letter, CCN **MCO** Comparison Chart, *et.al.*)~~
- **Submit Draft program materials (letters, notices, MCO comparison charts, *et. al*) as needed.**
- Submit monthly Enrollment Report
- Maintain electronic copies of all enrollment files exchanged with Medicaid Fiscal Intermediary and all contract Coordinated Care Networks

~~**2. Promoting Pro-active Choice of CCN MCOs**~~

- ~~Submit monthly report of number of CCN **MCO** potential enrollees who do **not** make a pro-active choice and must be automatically assigned to a CCN **MCO**~~
- ~~Submit survey plan to DHH for approval, for survey of enrollees who fail to pro-actively choose a CCN **MCO**~~
- ~~Maintain copies of surveys~~

- ~~Submit to DHH quarterly reports with survey results for enrollees who fail to pro-actively choose a CCN **MCO**~~
- ~~Submit written proposals for changes to written materials and protocols to increase pro-active selection percentage that are submitted by the Contractor to DHH for approval~~
- ~~Submit corrective action plan if 51% pro-active choice rate is not achieved for the contract year.~~

**2. ~~3.~~ Systems**

- Maintain evidence of successful exchange of files as verified by ~~CCN~~ **MCO** entities and Medicaid Fiscal Intermediary.

**3. ~~4.~~ Enrollee Call Center**

- Submit draft training materials for telephone agents
- Submit monthly reports

**4. ~~5.~~ Annual Open Enrollment**

- Submit written recommendation for Open Enrollment that complies with federal Medicaid requirements and allows for **an annual** open enrollment**.** ~~in an even flow throughout the year.~~
- Submit draft materials to be used in open enrollment packets.
- Submit Open Enrollment statistical reports.

**5. ~~6.~~ Processing Member Disenrollment Requests from ~~CCN~~ MCOs and Members**

- Submit report with the number of members who are automatically disenrolled from the ~~CCN~~ **MCO** because the Contractor fails to act timely on the request for disenrollment
- Submit monthly Disenrollment Report
- Submit Disenrollment Request Forms
- Maintain documentation of reason for approval or disapproval of Disenrollment Requests

**7. ~~CCN Calls to Verify 24/7 Access to Clinician~~**

- ~~Submit script and draft plan for placing monthly calls to PCPs to verify availability of 24/7 access to clinician within 30 minutes.~~
- ~~Submit required quarterly and annual reports of Verification Calls~~
- ~~Maintain notes from calls~~

**6. ~~8.~~ Required Reporting to DHH**

- Maintain minutes from meeting with DHH to finalize report contents
- Submit draft technical reports for DHH review and approval
- Submit completed checklist of required reports
- Maintain logs of submission of all contractually required reports

**7. 9~~. CCN~~ MCO Complaint Tracking and Reporting**

- Submit to DHH for approval the template for complaint tracking
- Timely submit monthly Complaint Tracking Reports, containing all required information.
- Maintain electronic records of all complaints, investigations, and resolutions

**8. ~~10.~~ Member Materials**

- Submit to DHH for approval all member materials
- Maintain copies of all member materials including obsolete versions
- Maintain documentation that reading level software was utilized, including indicator used and reading level of the item

**9. ~~11.~~ Build and Maintain Enrollment Website**

- Submit website screenshots to DHH for approval
- Maintain documentation that reading level software was utilized, including indicator used and reading level of the web page

**10. ~~12.~~ Applications**

- **Submit to DHH:**
  - **Number of applications completed**
  - **Number of applications aborted & cause(s)**
  - **Number of phone calls that did not result in an application completion**

- **Call volume, average length of call, call wait time, abandonment rate**

11. **~~13.~~ Renewals**
    - **Submit to DHH:**
        - **Number of renewal applications completed**
        - **Number of renewal applications aborted & cause(s)**
        - **Number of phone calls that did not result in a renewal completion**
            - **Number of those that were up for renewal**
            - **Number of those that were general information**
        - **Call volume, average length of call, call wait time, abandonment rate**

**Monitoring**

The individual assigned as the DHH Contract Monitor and point of contact between the DHH and the Contractor is Ruth Kennedy or her designee.

Ongoing monitoring of the Contractor's performance will include the following:

Thorough review and analysis of required monthly, quarterly and annual written reports, updates to work plans, and correspondence submitted by the Contractor, and if required, review, analysis, approval and follow-up of any Corrective Action Plan required by DHH from the Contractor.

Weekly status calls between Contractor's staff and the DHH Contract Monitor and other Medicaid staff to discuss issues as warranted;

Face-to-face meetings between Contractor's staff and the DHH Contract Monitor and other Medicaid staff to discuss issues as warranted;

Solicitation of feedback on Contractor's performance from ~~CCN~~ **MCOs**~~,~~ and the Medicaid Fiscal Intermediary, with whom the Contractor interacts;

Real time monitoring telephone hotline calls;

Investigation of complaints regarding the Contractor received from Medicaid enrollees, DHH employees, ~~CCN~~ **MCO** staff, other DHH Contractors, and legislators;

Spot checking that complaints made directly to the Contractor to verify investigation and resolution

Using Literacy Tools software package to independently test reading level of written member materials and website

Random checks of member disenrollment requests processed by the Contractor to verify validity of decision

Periodic navigation of enrollee website and smart phone application and testing on-line enrollment feature;

Spot checking that provider listings for ~~CCN~~ **MCO**s on enrollee website accurately reflect information reported to the Contractor by ~~CCN~~ **MCO**s;

Unannounced as well as scheduled visits to Contractor's ~~Baton Rouge~~ administrative office; and

"Secret shopper" calls to Enrollee Hotline.

~~**LEFT BLANK INTENTIONALLY**~~