REQUEST FOR PROPOSALS

PREPAID COORDINATED CARE NETWORKS

LOUISIANA MEDICAID COORDINATED CARE PROGRAM

BUREAU OF HEALTH SERVICES FINANCING

DEPARTMENT OF HEALTH AND HOSPITALS

RFP # 305PUR-DHHRFP-CCN-P-MVA

Proposal Due Date/Time: 6/24/2011/4:00 PM CDT

Release Date: 4/11/2011

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1.0 GENERAL INFORMATION

1.1. Background

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

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

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

1.1.4. 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, Eligibility Systems, and Health Standards. The Medicaid Coordinated Care Section has primary responsibility for implementation and ongoing operations of all Medicaid coordinated care delivery models, including Coordinated Care Networks (CCNs).

1.2. Purpose of RFP

1.2.1. The purpose of this Request for Proposals (RFP) is to solicit proposals from qualified entities to provide 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.

1.2.2. Through this RFP, DHH will solicit proposals from entities to serve as a Prepaid Coordinated Care Network (CCN-P) in three (3) Geographic Service Areas (GSAs) within the state. The GSAs are comprised of DHH Administrative Regions as follows:

1.2.2.1. GSA "A": DHH Administrative Regions 1 and 9

- Region 1:
  - Jefferson
  - Plaquemines
  - Orleans

- St. Bernard

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

1.2.2.2. 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

1.2.2.3. 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 GSA Map

1.2.3. DHH anticipates that the implementation of the Louisiana Medicaid CCN Program will achieve the following outcomes:

1.2.3.1. Improved coordination of care;
1.2.3.2. A patient-centered medical home for Medicaid recipients;
1.2.3.3. Better health outcomes;
1.2.3.4. Increased quality of care as measured by metrics such as HEDIS;
1.2.3.5. Greater emphasis on disease prevention and management of chronic conditions;
1.2.3.6. Earlier diagnosis and treatment of acute and chronic illness;
1.2.3.7. Improved access to essential specialty services;

1.2.3.8. Outreach and education to promote healthy behaviors;
1.2.3.9. Increased personal responsibility and self management;
1.2.3.10. A reduction in the rate of avoidable hospital stays and readmissions;
1.2.3.11. A decrease in fraud, abuse, and wasteful spending;
1.2.3.12. Greater accountability for the dollars spent;
1.2.3.13. A more financially sustainable system; and
1.2.3.14. Net savings to the state compared to the existing fee-for-service Medicaid delivery system.

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

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

1.2.6. This RFP process is being used so that DHH may selectively contract with up to three (3) CCN-P entities in each GSA but no more than required to meet Medicaid enrollment capacity requirements and assure choice for Medicaid recipients as required by federal statute. The number of awards in each GSA is at the sole discretion of the Secretary. The RFP will provide DHH with the opportunity to ensure that the CCN-P is capable of implementing an acceptable care management system that provides for a medical home.

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

1.2.8. State authority for DHH to implement the CCN Program is contained in L.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.

1.2.9. 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 apply to Medicaid managed care organizations (MCOs). DHH intends to submit a State Plan Amendment to implement the CCN Program.

1.3. 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 capitation payment 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.

1.4. RFP Coordinator

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

Ruth Kennedy
Medicaid CCN Director
Louisiana Department of Health and Hospitals
628 North 4th Street, Baton Rouge, LA 70802
Telephone Number: (225) 342-3032
Cell Number: (225) 241-1437
Facsimile Number: (225) 376-4808
E-mail: Ruth.Kennedy@LA.GOV

1.4.2. This RFP is available at the following web links:

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

1.5. Communications

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 shall be strictly prohibited. Failure to comply with these requirements shall result in proposal disqualification.

1.6. Proposer Comments

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

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

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

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

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

Submitter Name	Document Reference (*e.g.*, RFP, RFP Companion Guide)	Section Number	Section Heading	Page Number in Referenced Document	Question

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

http://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

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

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

1.7. Notice of Intent to Propose

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

1.7.1.1. Company name

1.7.1.2. DHH Geographic Service Areas (GSAs) the potential proposer may propose to serve

1.7.1.3. Name and title of a contact person

1.7.1.4. 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.

1.7.2. Copies of Notices of Intent to Propose received by DHH will be posted upon receipt at the web links listed above.

1.8. Pre-Proposal Conference

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

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

http://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

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

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

1.9. Schedule of Events

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

SCHEDULE OF EVENTS	TENTATIVE SCHEDULE
Public Notice of RFP	April 11, 2011
Proposal Conference	April 18, 2011 9:00 A.M.– Noon CDT Room 118 Bienville Building 628 North 4th Street Baton Rouge, LA 70802
Rate Conference	April 19, 2011 9:00A.M. to Noon CDT Room 118, Bienville Building 628 North 4th St Baton Rouge, LA 70802

Systems and Technical Conference	April 19, 2011 1:00 P.M-4:00 P.M. CDT Room 118, Bienville Building 628 North 4th St Baton Rouge, LA 70802
Deadline for Receipt of Written Questions	April 29, 2011 11:00 P.M. 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
Deadline for Receipt of Follow-Up Written Questions	May 27, 2011 11 P.M. CDT
Deadline for DHH Responses to Follow-Up Written Questions	June 10, 2011
Deadline for Receipt of Written Proposals	June 24, 2011 4:00 CDT
Proposal Evaluation Begins	June 25, 2011
Contract Award Announced	July 25, 2011
Contract Negotiations Begin	July 25, 2011 – August 8 2011
Contracts Signed by CCN and DHH (Subject to OCR and CMS Approval)	August 8, 2011
Contracts Submitted to DOA/OCR for Approval	August 8, 2011
Deadline for DOA/OCR Approval	September 1, 2011

GSA "A"	
Readiness Reviews Begin	September 1, 2011
GSA Network Adequacy Documentation Deadline	October 7, 2011
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
GSA "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
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
GSA "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
"Go Live" Date for GSA	May 1, 2012

1.10. RFP Addenda

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

http://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

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

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2.0 SCOPE OF WORK

2.1. Requirements for CCN-P Entity

2.1.1. In order to participate as an managed care organization (MCO), prepaid model CCN (CCN-P), an entity must:

2.1.1.1. meet the federal definition of a Medicaid managed care organization as defined in Section 1903 (m) of the Social Security Act as amended and 42 CFR §438.2;

2.1.1.2. have a license or certificate of authority issued by the Louisiana Department of Insurance (DOI) to operate as a Medicaid risk bearing entity pursuant to Title 22:1016 of the Louisiana Revised Statutes no later than July 15, 2011, and submit to DHH within 30 days from the date the CCN signs the contract with DHH;

2.1.1.3. be certified by the Louisiana Secretary of State, pursuant to R.S. 12:24, to conduct business in the state, and submit to DHH within 30 days from the date the CCN signs the Contract with DHH;

2.1.1.4. meet solvency standards as specified in federal regulations and Title 22 of the Louisiana Revised Statutes;

2.1.1.5. meet NCQA or URAC Health Plan Accreditation or agree to submit an application for accreditation at the earliest possible date allowed by NCQA or URAC and once achieved, maintain accreditation through the life of this Contract;

2.1.1.6. have a network capacity to enroll a minimum of 75,000 Medicaid members into the network in each DHH designated GSA for which a proposal is being submitted;

2.1.1.7. not have an actual or perceived conflict of interest that, in the discretion of DHH, would interfere or give the appearance of possibly interfering with its duties and obligations under this Contract or any other contract with DHH, and any and all appropriate DHH written policies. Conflict of interest shall include, but is not limited to, being the Medicaid fiscal intermediary contractor for the Department;

2.1.1.8. be a successful proposer, be awarded a contract with DHH, and successfully complete the Readiness Review prior to the start date of operations;

2.1.1.9. be willing and able to provide core benefits and services to all assigned members, whether chosen or auto-assigned, on the day the Medicaid CCN Program is implemented in the GSA.

2.1.2. An entity can submit a proposal for both the CCN - Shared Savings (CCN-S) model and the CCN-Prepaid (CCN-P) model within the same GSA and provide services under both models if they are awarded a Contract for each.

2.2. CCN Project Overview

2.2.1. The Coordinated Care Network-Prepaid (CCN-P) is a risk-bearing, Managed Care Organization (MCO) health care delivery system responsible for providing specified Medicaid core benefits and services included in the Louisiana Medicaid State Plan to Medicaid recipients in a designated geographical service area (GSA). The CCN-P 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.

2.2.2. Beginning November 2011, DHH will phase-in implementation of member enrollment services into Medicaid's Coordinated Care Network (CCN) Program. Member enrollment into the Coordinated Care Program will be phased in based on DHH's GSAs. Services will begin January 1, 2012 for GSA A; March 1, 2012 for GSA B; and May 1, 2012 for GSA C. (See Schedule of Events).

2.2.3. A CCN-P assumes full risk for the cost of core benefits and services under the Contract and incurs loss if the cost of furnishing these core benefits and services exceeds the payment received for providing these services.

2.2.4. DHH shall establish a Per Member Per Month (PMPM) actuarially sound risk-adjusted rate to be paid to the CCN. The rates shall not be subject to negotiation or dispute resolution. The rate is intended to cover all benefits and management services outlined in this RFP.

2.2.5. Management services include but are not limited to:

2.2.5.1. Utilization Management

2.2.5.2. Quality Management and Compliance

2.2.5.3. Prior Authorization

2.2.5.4. Provider Monitoring

2.2.5.5. PCP Patient-Centered Medical Home Recognition, or Primary Care Home Accreditation

2.2.5.6. Member and Provider Services

2.2.5.7. PCP Primary Care Management

2.2.5.8. Fraud and Abuse Monitoring and Compliance

2.2.5.9. Case Management

2.2.5.10. Chronic Care Management

2.2.5.11. Account Management

2.3. General CCN Requirements

2.3.1. The CCN-P (hereafter called CCN in this RFP) shall provide DHH with full and complete information on the identity of each person or corporation with an ownership interest of five percent or greater (5%+) in the CCN, or any subcontractor in which the CCN has 5% or more ownership interest. The CCN shall also provide such required information including, but not limited to financial statements, for each person or entity with ownership or controlling interest of 5% or more in the CCN and any of its subcontractors, including all entities owned or controlled by a parent organization. This information shall be provided to DHH on the approved Disclosure Form and whenever changes in ownership occur.

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

The CCN's administrative office shall maintain normal business hours of 8:00 a.m. to 5:00 p.m. CST Monday through Friday, excluding recognized Louisiana state holidays and be operational on all DHH regularly scheduled business days. A listing of state holidays may be found at:
http://www.civilservice.la.gov/OtherInfo/StateEmployeesInfo/bene%20HOLIDAYS.asp

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

2.3.4. 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 risk based managed care plans are specified in section 1903(m) of the Social Security Act and 42 CFR Part 438 and will govern this Contract. DHH is not precluded from implementing any changes in state or federal statutes, rules or administrative procedures that become effective during the term of this Contract and will implement such changes pursuant to Section § 23 of this RFP.

2.3.5. The CCN must maintain policy and procedures concerning advance directives with respect to all adult individuals receiving medical services by or through the CCN in accordance with 42 CFR §489 and 42 CFR §438.6(i)(1). The written information provided by the CCN must reflect any changes in Louisiana law as soon as possible, but no later than 90 days after the effective date of the change.

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

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

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

2.4. Moral and Religious Objections

2.4.1. If a CCN elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the CCN must furnish information about the services it does not cover in accordance with 1932(b)(3)(B)(ii) and 42 CFR §438.102(b)(1) by notifying:

2.4.1.1. DHH with its proposal whenever it adopts the policy during the term of the Contract;

2.4.1.2. Potential enrollees before and during enrollment in the CCN;

2.4.1.3. Enrollees within ninety (90) days after adopting the policy with respect to any particular service; and

2.4.1.4. Members through the inclusion of the information in the Member's Manual.

2.4.2. If a CCN elects not to provide, reimburse for, or provide coverage of a core benefit or service because of an objection on moral or religious grounds, the monthly capitation payment for that CCN will be recalculated.

2.5. Insurance Requirements

2.5.1. General Insurance Information

2.5.1.1. 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 be named as the insured on the policy.

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

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

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

2.5.2. Workers' Compensation Insurance

2.5.2.1. 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.

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

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

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

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

2.5.3. Commercial Liability Insurance

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

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

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

2.5.4. Reinsurance

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

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

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

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

2.5.5. Errors and Omissions Insurance

2.5.5.1. 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.

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

2.5.6. Insurance Covering Special Hazards

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

2.5.7. Licensed and Non-Licensed Motor Vehicles

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

2.5.8. Subcontractor's Insurance

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

2.6. Bond Requirements

2.6.1. Performance Bond or Substitute

2.5.1.1. The CCN shall be required to establish and maintain a performance bond of ten (10) million dollars ($10,000,000) 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 this contract [42 CFR 438.116].

2.5.1.2. The bond must be obtained from an agent appearing on the United States Department of Treasury’s list of approved sureties. The performance bond must be made payable to the state of Louisiana. The contract and dates of

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

2.5.1.3. In the event that DHH exercises an option to renew the Contract for an additional period, the 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.

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

- Paying any damages because of a breach of the 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.

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

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

2.6.2. Fidelity Bond

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

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

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3.0 ELIGIBILITY

3.1 Eligibility Determinations

3.1.1. DHH determines eligibility for Medicaid and CHIP for all coverage groups with the exception of Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF) (which is known in Louisiana as the Family Independence Temporary Assistance Program (FITAP)) and Foster Care/Children in out of home placement.

3.1.2. The Social Security Administration (SSA) determines eligibility for SSI and the Louisiana Department of Children and Family Services (DCFS) determines eligibility for TANF/FITAP and Foster Care.

3.1.3. Once an applicant is determined eligible for Medicaid or CHIP by DHH, SSA or DCFS, the pertinent eligibility information is entered in the Medicaid Eligibility Determination System (MEDS).

3.2 Eligibility Criteria

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

3.3 Duration of Medicaid Eligibility

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

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

3.3.3 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.

3.4 Mandatory CCN Populations

Medicaid groups mandated to participate in CCN include the following:

3.4.1 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:

3.4.1.1 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;

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

3.4.1.3 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;

3.4.1.4 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;

3.4.1.5 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;

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

3.4.1.7 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.

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

3.4.2.1 Section 1931 LIFC Program

3.4.2.2 TANF (FITAP) Program

3.4.2.3 Regular Medically Needy Program

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

3.4.3.1 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

3.4.3.2 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.

3.4.4 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.

3.4.5 Aged, Blind and Disabled Adults – Individuals, 19 or older, who do not meet any of the conditions for exclusion from participation in a CCN, including:

3.4.5.1 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

3.4.5.2 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;

- 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:

  o 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- Widows/Widowers who are not entitled to Part A Medicare who become ineligible for SSI due to receipt of SSA Disabled Widows/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 was 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.

3.5 Voluntary CCN Populations

Medicaid groups whose eligibility in the CCN Program is voluntary include the following:

3.5.1 Children under 19 years of age who are:

3.5.1.1 Eligible for SSI under title XVI;

3.5.1.2 Eligible under section 1902(e)(3) of the Act;

3.5.1.3 In foster care or other out-of-home placement;

3.5.1.4 Receiving foster care or adoption assistance;

3.5.1.5 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

3.5.1.6 Enrolled in the Family Opportunity Act Medicaid Buy-In Program.

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

3.5.2.1 The Indian Health Service; or

3.5.2.2 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.

3.6 Excluded CCN Populations

Medicaid groups that cannot voluntarily enroll with a CCN and are excluded include:

3.6.1 Individuals receiving hospice services;

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

3.6.3 Individuals who receive both Medicaid and Medicare (Medicare dual eligibles);

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

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

3.6.5.1 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;

3.6.5.2 New Opportunities Waiver (NOW) – Services to individuals who would otherwise require ICF/DD services;

3.6.5.3 Elderly and Disabled Adult (EDA) - Services to persons aged 65 and older or disabled adults who would otherwise require nursing facility services;

3.6.5.4 Children's Choice (CC) - Supplemental support services to disabled children under age 18 on the NOW waiver registry;

3.6.5.5 Residential Options Waiver (ROW) – Services to individuals living in the community who would otherwise require ICF/DD services;

3.6.5.6 Supports Waiver – Services to individuals 18 years and older with mental retardation or a developmental disability which manifested prior to age 22; and

3.6.5.7 Other HCBS waivers as may be approved by CMS.

3.6.6 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;

3.6.7 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;

3.6.8 Individuals with a limited eligibility period including:

3.6.8.1 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 (3) months);

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

3.6.8.3 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;

3.6.9 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;

3.6.10 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 the Medicaid program; and

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

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4.0 STAFF REQUIREMENTS AND SUPPORT SERVICES

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

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), 42 CFR §1001.1901(b), 42 CFR §1003.102(a)(2)]. The CCN must screen all employees and sub-contractors to determine whether any of them have been excluded from participation in federal health care programs. The HHS-OIG website, which can be searched by the names of any individual, can be accessed at the following url: http://www.oig.hhs.gov/fraud/exclusions.asp

The 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 monetary penalties as specified in Section 20 of this RFP.

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

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

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

4.1. Key Staff Positions

4.1.1. 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.

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

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

4.1.4. 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.

4.1.5. 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.

4.1.6. 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. 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].

4.1.6.1. Administrator/CEO/COO or their designee must serve in a full time (40 hours weekly) position available during DHH working hours to fulfill the responsibilities of the position and to oversee the entire operation of the 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.

4.1.6.2. 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, discharge planning, credentialing 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.

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

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

4.1.6.5. Grievance System Management 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.

4.1.6.6. 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.

4.1.6.7. 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 coordinating the tracking and submission of all contract deliverables; fielding and coordinating responses to DHH inquiries, coordinating the preparation and execution of contract requirements, random and periodic audits and *ad hoc* visits.

4.1.6.8. 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:

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

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

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

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

4.1.6.10. Maternal Child Health/EPSDT Coordinator who is a Louisiana licensed registered 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 MCH/EPSDT Coordinator are:

- Ensuring receipt of EPSDT services;
- Ensuring receipt of maternal and postpartum care;
- Promoting family planning services;
- Promoting preventive health strategies;
- Identifying and coordinating assistance for identified member needs specific to maternal/child health and EPSDT;
- Interfacing with community partners.

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

- Ensuring adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria;
- Ensuring that appropriate concurrent review and discharge planning of inpatient stays is conducted;
- Developing, implementing and monitoring the provision of care coordination, disease management and case management functions;

- Monitoring, analyzing and implementing appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services; and

- Monitoring prior authorization functions and assuring that decisions are made in a consistent manner based on clinical criteria and meet timeliness standards.

4.1.6.12. Provider Services Manager to coordinate communications between the CCN and its subcontracted providers.

4.1.6.13. Member Services Manager 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.

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

- Developing and implementing claims processing systems capable of paying claims in accordance with state and federal requirements and the terms of the Contract

- Developing processes for cost avoidance;

- Ensuring minimization of claims recoupments;

- Meeting claims processing timelines;

- Meeting DHH encounter reporting requirements.

4.1.6.15. Provider Claims Educator must be full-time (forty [40] hours per week) employee for a CCN with over 100,000 members statewide. This position is fully integrated with the CCN's grievance, claims processing, and provider relations systems and facilitates the exchange of information between these systems and providers, with a minimum of five (5) years management and supervisory experience in the health care field. The primary functions of the Provider Claims Educator are:

- Educating in-network and out-of-network providers (*i.e.,* professional and institutional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, and available CCN resources such as provider manuals, websites, fee schedules, etc.;

- Interfacing with the CCN's call center to compile, analyze, and disseminate information from provider calls;

- Identifying trends and guiding the development and implementation of strategies to improve provider satisfaction;

- Frequently communicating (*i.e*., telephonic and on-site) with providers to ensure the effective exchange of information and to gain feedback regarding the extent to which providers are informed about appropriate claims submission practices;

4.1.6.16. 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.

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

4.1.7. Additional Required Staff

4.1.7.1. Prior Authorization Staff to authorize health care 24 hours per day, 7 days per week. This staff shall include a Louisiana licensed registered nurse, physician or physician's assistant. The staff will work under the direction of a Louisiana-licensed registered nurse, physician or physician's assistant.

4.1.7.2. Concurrent Review Staff to conduct inpatient concurrent review. This staff shall include of a Louisiana licensed nurse, physician, or physician's assistant. The staff will work under the direction of a Louisiana licensed registered nurse, physician or physician's assistant.

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

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

4.1.7.5. Member Services Staff to enable members to receive prompt responses and assistance. There shall be sufficient Member Services staff to enable members and potential members to receive prompt resolution of their problems or inquiries.

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

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

4.1.7.8. Case Management Staff to assess, plan, facilitate and advocate options and services to meet the enrollees' health needs through communication and available resources to promote quality cost-effective outcomes.

4.2. In-State Positions

The CCN is responsible for maintaining a significant local (within the state of Louisiana) presence. Positions that should be located in Louisiana are the following:

4.2.1. Administrator/CEO/COO
4.2.2. Medical Director/CMO
4.2.3. Compliance Officer
4.2.4. Grievance System Manager
4.2.5. Contract Compliance Officer
4.2.6. Quality Management Coordinator
4.2.7. Maternal Health/EPSDT (Child Health) Coordinator
4.2.8. Medical Management Coordinator
4.2.9. Provider Services Manager
4.2.10. Provider Claims Educator (if applicable)

4.3. Written Policies, Procedures, and Job Descriptions

4.3.1. 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.

4.3.2. 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.

4.4. Staff Training and Meeting Attendance

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

4.4.2. 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.

4.4.3. New and existing transportation, 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; recommending providers in; and transporting members to the most geographically appropriate location.

4.4.4. 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.

4.4.5. 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 § 12 Marketing and Member Materials), time and location, at least fourteen (14) calendar days prior to the actual date of training.

4.5. Annual Reporting to DHH

The CCN must submit to the DHH the following items annually:

4.5.1. An updated organization chart complete with the Key Staff positions. The chart must include the person's name, title and telephone number and portion of time allocated to the Louisiana Medicaid contract, other Medicaid contracts, and other lines of business.

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

4.5.3. 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.

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5.0 CCN REIMBURSEMENT

DHH shall make monthly risk-adjusted 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.

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

5.1. Annual Actuarial Study

DHH will retain a qualified actuary to conduct an annual actuarial study of the CCN program. The CCN shall provide in writing any information requested by DHH to assist the actuary in completion of the annual actuarial study. DHH will give the CCN reasonable time to respond to the request and full cooperation by the CCN is required. DHH will make the final determination as to what is considered reasonable.

5.2. Maternity Kick Payments

In addition to the monthly capitated rate, DHH shall provide CCNs a one-time supplemental lump sum payment for each obstetrical delivery. This kick payment is intended to cover the cost of prenatal care, the delivery event, and post-partum care and normal newborn hospital costs.

5.2.1. Only one maternity kick payment will be made per delivery event. Multiple births during the same delivery will result in one maternity kick payment being paid. The maternity kick payment will be paid for both live and still births. A kick payment will not be reimbursed for abortions or spontaneous abortions (spontaneous abortions as defined in state statute). The amount of the kick payment will be determined by DHH's actuary.

5.2.2. The kick payment will be paid to the CCN upon submission of satisfactory evidence of the occurrence of a delivery. CCNs shall require hospitals to accurately input the delivery event into the Louisiana Electronic Event Registration System (LEERS) in order for a kick payment request to be initiated to DHH's fiscal intermediary (FI) for payment to the CCN.

5.3. CCN Payment Schedule

5.3.1. The risk-adjusted monthly capitated payment shall be based on member enrollment for the month and paid in the weekly payment cycle nearest the 15th calendar day of the month (see Appendix V – **Fiscal Intermediary (FI) Payment Schedule**). 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.

5.3.1.1. The CCN shall make payments to its providers as stipulated in the contract.

5.3.1.2. The CCN shall not assign its right to receive payment to any other entity.

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

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

5.4. Payment Adjustments

5.4.1. In the event that an erroneous payment is made to the CCN, DHH shall reconcile the error by adjusting the CCN's next monthly capitation payment.

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

5.4.3. In cases of a retroactive effective date for Medicare enrollment of a member, the CCN will recoup payments made to the providers. The CCN shall instruct the provider to resubmit the claim(s) to Medicare and secondarily to the Medicaid fee-for-service program (if applicable).

5.4.4. The CCN will refund payments received from DHH for a deceased member's effective month of service that is after the month of death. DHH will recoup the payment as specified in the contract.

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

5.5. Risk Sharing

The CCN shall assume one hundred percent (100%) liability for any expenditure above the monthly capitation rate.

5.6. Determination of CCN Rates

5.6.1. DHH has developed cost-effective and actuarially sound rates according to all applicable CMS rules and regulations. DHH will not use a competitive bidding process to develop the CCN capitation. DHH will develop monthly capitation rates that will be offered to CCNs on a "take it or leave it" basis.

5.6.2. Initial rates will be set using FFS claims data for State Fiscal Years (SFY) 2009 and 2010, with appropriate adjustments which include the following:

5.6.2.1. The expected impact of managed care on the utilization of the various types of services (some increases and some reductions);

5.6.2.2. Unit cost trend;

5.6.2.3. Medicaid program changes;

5.6.2.4. Third Party Liability recoveries; and

5.6.2.5. The expected cost of CCN administration and overhead.

5.6.3. Additional factors determining the rate for an individual member are 1) age, 2) gender, 3) Medicaid category of assistance, 4) DHH administrative region as defined in Louisiana statutes that the member resides in.

5.6.4. As the CCN Program matures and FFS data is no longer available, there will be increasing reliance on encounter data and/or financial data to set future rates, subject to comparable adjustments.

5.6.5. The CCN shall be paid in accordance with the monthly capitated rates specified in Appendix G – **Mercer Certification, Rate Development Methodology and Rates** of this RFP.

5.6.6. The rates will be reviewed and may be periodically adjusted. Any adjusted rates shall be actuarially sound and consistent with requirements set forth in 42 CFR §438.6 (c)(2005, as amended).

5.7. Risk Adjustment

5.7.1. DHH will analyze the risk profile of members enrolled in each CCN using the Adjusted Clinical Groups (ACGs) developed by Johns Hopkins University. Each member will be assigned an ACG category, which has a calculated risk score or cost weight that reflects anticipated utilization of health care services relative to the overall population. These cost weights will be developed using Louisiana specific historical data from Medicaid fee-for-service claims. Each CCN's proposed base capitation rates will be risk adjusted based on the CCN's risk score that reflects the expected health care expenditures associated with its enrolled members relative to the overall (all CCNs) population. For each of the three implementation phases, risk adjustment will be completed and effective ninety (90) days following implementation.

5.7.2. DHH will provide the CCN with three (3) months advance notice of any major revision to the risk-adjustment methodology. The CCN will be given fourteen (14) days to provide input on the proposed changes. DHH will consider the feedback from the CCNs in the changes to the risk adjustment methodology.

5.8. Other Rate Adjustments

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

5.9. Medical Loss Ratio

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

5.10. Co-payments

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

5.11. Return of Funds

5.11.1. All amounts owed by the CCN 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 is published by HHS in the Federal Register.

5.11.2. 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

5.12. Third Party Liability (TPL)

5.12.1. General TPL Information

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

5.12.1.2. The CCN shall take reasonable measures to determine Third Party Liability.

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

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

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

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

5.12.2. Cost Avoidance

5.12.2.1. The CCN shall cost-avoid a claim if it establishes the probable existence of Third Party Liability at the time the claim is filed.

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

5.12.2.3. The CCN shall adjudicate claims for medical treatment associated with labor, delivery and EPSDT in accordance with federal and state law.

5.12.2.4. If a Third Party Liability insurer requires the member to pay any co-payment, coinsurance or deductible, the CCN is responsible for making these payments under the method described below, even if the services are provided outside of the CCN network.

Scenario 1 Professional Claim

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility Amount	Medicaid Payment
99212	55.00	0.00	24.10	36.00 (Ded)	24.10
83655-QW	30.00	0.00	11.37	28.20 (Ded)	11.37
Totals	85.00	0.00	35.47	64.20 (Ded)	35.47

(Medicaid pays the allowable amount minus TPL payment OR total patient responsibility amount (co-pay, co-insurance, and/or deductible). The Medicaid allowed amount minus the TPL paid amount is LESS than the patient responsibility; thus, the Medicaid allowed amount is the payment.)

Scenario 2 Outpatient Claim

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility Amount	Medicaid Payment
HR270	99.25	74.44	22.04	0.00	0.00
HR450	316.25	137.19	70.24	100.00	0.00
Total	415.50	211.63	92.28	100.00	0.00

(Medicaid "zero pays" the claim. When cost-compared, the private insurance paid more than Medicaid allowed amount for the procedure. When compared, the lesser of the Medicaid allowed amount minus the TPL payment AND the patient responsibility is the former; thus, no further payment is made by Medicaid. The claim is paid in full.)

Scenario 3 Inpatient Claim

Procedure Code	Billed Charge	TPL Paid Amount	Medicaid Allowed Amount	Patient Responsibility Amount	Medicaid Payment
Multiple HR	12,253.00	2,450.00	5,052.00	300.00	300.00

(The Medicaid allowed amount minus the TPL payment is greater than the co-pay; thus, the co-pay is paid on this covered service.)

5.12.3. Post-payment Recoveries

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

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

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

5.12.3.4. The CCN must report the existence of Third Party Liability, to the DHH contracted vendor on a monthly basis by the fifteenth (15th) working day of the month from the date of discovery.

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

5.12.3.6. The amount of any recoveries collected by the CCN outside of the claims processing system shall be treated by the CCN as offsets to medical expenses for the purposes of reporting.

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

5.12.4. Distribution of TPL Recoveries

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

5.12.4.1. Total collections received do not exceed the total amount of the CCN financial liability for the member;

5.12.4.2. There are no payments made by DHH related to fee-for-service, reinsurance or administrative costs (*i.e,* lien filing, etc.)

5.12.4.3. Such recovery is not prohibited by state or federal law, and;

5.12.4.4. DHH will utilize the data in calculating future capitation rates.

5.12.5. TPL Reporting Requirements

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

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

5.12.5.3. Upon the request of DHH, the CCN must provide information not included in encounter data submissions that may be necessary for the administration of Third Party Liability activity. The information must be provided within

thirty (30) calendar days of DHH's request. Such information may include, but is not limited to, individual medical records for the express purpose of a Third Party Liability resource to determine liability for the services rendered.

5.12.5.4. The CCN shall report members with third party coverage to DHH on a monthly basis by the fifteenth (15th) working day of the month.

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

5.12.5.6. The CCN is required to submit an annual report of all health insurance collections for its members plus copies of any Form 1099's received from insurance companies for that period of time.

5.12.6. DHH Right to Conduct Identification and Pursuit of TPL

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

5.12.6.2. If DHH determines that the CCN is not actively engaged in cost avoidance activities the CCN shall be subject to monetary penalties in an amount not less than three times the amount that could have been cost avoided.

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6.0 CORE BENEFITS AND SERVICES

6.1. General Provisions

6.1.1. The CCN shall have available for members, at a minimum, those core benefits and services specified in the Contract and as defined in the Louisiana Medicaid State Plan, administrative rules and DHH policy and procedure manuals. The CCN shall possess the expertise and resources to ensure the delivery of quality health care services to CCN members in accordance with Louisiana Medicaid program standards and the prevailing medical community standards.

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

6.1.3. Although the CCN shall provide the full range of required core benefits and services listed below in Section § 6.1.5.1, they may choose to provide services over and above those specified when it is cost effective to do so. The CCN may offer additional benefits that are outside the scope of core benefits and services to individual members on a case-by-case basis, based on medical necessity, cost-effectiveness, the wishes of the member and/or /member's family, the potential for improved health status of the member, and functional necessity. Examples include substance abuse services for pregnant women; pain management for members with sickle cell anemia, dental services for adults, eyeglasses for adults, and over-the- counter medications.

6.1.4. If new services are added to the Louisiana Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contract shall be amended and the CCN given not less than sixty (60) days advance notice of the change.

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

6.1.5. The CCN shall provide core benefits and services to Medicaid members. The core benefits and services that shall be provided to members are:

- Audiology Services
- Inpatient Hospital Services
- Outpatient Hospital Services
- Ambulatory Surgical Services
- Ancillary Medical Services
- Lab and X-ray Services
- Medical and surgical Dental Service
- Diagnostic Services
- Organ Transplant and Related Services

- Family Planning Services (not applicable to CCN operating under Section §6.1.13 of this RFP)
- Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Emergency Medical Services
- Communicable Disease Services
- Durable Medical Equipment, Prosthetics, Orthotics and Certain Supplies
- Emergency Dental Services
- Emergency and Non-emergency Medical Transportation
- Home Health Services
- Basic Behavioral Health Services
- Clinic Services
- Physician Services
- Pregnancy-Related Services
- Nurse Midwife Services
- Nurse Practitioner Services
- Chiropractic Services (Age 0-20)
- Federally Qualified Health Center (FQHC) Services (including behavioral services provided by FQHCs)
- Rural Health Clinic Services
- Immunizations (Children and Adults)
- End Stage Renal Disease Services
- Home Health-Extended Services (Age 0-20)
- Eye Care and Vision Services
- Podiatry Services
- Private Duty Nursing Services
- Rehabilitative Services
- Therapy Services (Physical, Occupational, Speech and Respiratory)

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

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

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

6.1.9. The CCN may exceed the service limits as specified in the Louisiana Medicaid State Plan to the extent that those service limits can be exceeded with authorization in fee-for-service. No medical service limitation can be more restrictive than those that currently exist under the Louisiana Medicaid State Plan.

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

See definition of "medically necessary services" in the Glossary. DHH shall make the final interpretation of any disputes about the medical necessity and continuation of core benefits and services under this RFP based on whether or not the Medicaid fee-for-service program would have provided the service.

6.1.11. The CCN 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 services for pregnant women in accordance with 42 CFR Part 440 Subpart B.

6.1.12. The CCN shall not portray core benefits or services as an expanded health benefit.

6.2. Eye Care and Vision Services

The CCN shall provide coverage of vision services that are performed by a licensed ophthalmologist or optometrist, conform to accepted methods of screening, diagnosis and treatment of eye ailments or visual impairments/conditions for members. Medicaid covered eye wear services provided by opticians are available to enrollees who are under the age of 21. A CCN shall not require a referral for in-network providers.

6.3. Behavioral Health Services

6.3.1. 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, licensed professional counselors, 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.

6.3.2. For the purposes of this RFP, behavioral health services are divided into two levels:

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

6.3.2.2. Specialized mental health services shall include, but are not be limited to services specifically defined in the Medicaid State Plan and provided by a psychiatrist, psychologist, and/or mental health rehabilitation provider to those enrollees with a primary diagnosis of a mental and/or behavioral disorder. These services shall be paid on a fee-for-service basis by DHH within the limitations and durations as set forth in the Medicaid State Plan.

6.3.3. Criteria for screening protocols and determining whether an individual meets the criteria for specialized behavioral health services shall be determined by DHH and are based on factors relating to age, diagnosis, disability (acuity) and duration of the mental health illness/condition.

6.3.4. Basic Behavioral Health Services

6.3.4.1. The CCN shall be responsible for providing basic behavioral health benefits and services to all members. Basic behavioral health services may further be defined as those provided in the member's PCP or medical office by the member's (non-specialist) physician (i.e., DO, MD, ARNP) as part of routine physician evaluation and management activities (*e.g.*, CPT codes 99201 through 99204),and all behavioral health services provided at FQHCs/RHCs). The CCN shall utilize the screening tools and protocols approved by DHH. The CCN shall be required to work with PCPs to implement screening tools for basic behavioral health, such as the Patient Health Questionnaire, (PHQ-9) and the Pediatric Symptom Checklist (PSC, Y-PHC), which are subject to approval by DHH. The CCN is financially responsible for the provision of these services.

6.3.4.2. 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.
- Medical services to be covered by the CCN include the following, but are not limited to:
  - Inpatient hospital services based on medical necessity, including:

    Acute Medical Detoxification providing 24-hour availability of non-surgical medical treatment for acute intoxication and/or life threatening conditions, under the direction of a physician in a hospital or other suitably equipped medical setting, with continuous services to persons afflicted with an alcohol and/or drug related crisis. In addition to having a physician's direction, one registered nurse or one licensed practical nurse must be on duty 24 hours per day for every 10 patients.

6.4. Laboratory and Radiological Services

6.4.1. The CCN shall provide inpatient and outpatient diagnostic testing and radiological services ordered and/or performed by all network providers.

6.4.2. For excluded services such as dental, the CCN is responsible for laboratory or radiological services that may be required to treat an emergency or provide surgical services.

6.4.3. The CCN shall provide for clinical lab services and portable (mobile) x-rays for members who are unable to leave their place of residence without special transportation or assistance to obtain PCP ordered laboratory services and x-rays.

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

6.5. EPSDT Well Child Visits

6.5.1. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is a comprehensive and preventive 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) and the CMS Medicaid State Manual).The program consists of two mutually supportive, operational components: (1) ensuring 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.

6.5.2. 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. These articles outline the requirements for EPSDT, including assurance that all EPSDT eligible members are notified of EPSDT available services; that 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.

6.5.3. 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 **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 and the Contract.

6.5.4. In Louisiana the screening component of this program in fee-for-service Medicaid has been known as Louisiana KIDMED. The CCN is required to fulfill the medical, vision, and hearing screening components and immunizations as specified in the periodicity charts in DHH's KIDMED Manual.

6.5.5. The CCN shall accurately report, via encounter data submissions 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 (Appendix HH – **EPSDT Reporting**). Instructions on how to complete the CMS 416 report may be found on CMS's website at:

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

See ***CCN-P Systems Companion Guide*** for format and timetable for reporting of EPSDT data.

6.5.6. DHH shall use encounter data submissions to determine the CCN's compliance with the state's established EPSDT goals of ensuring:

6.5.6.1. 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

6.5.6.2. 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

6.5.6.3. 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.

6.5.7. Some EPSDT preventive screening claims should be submitted sooner than within 12 months from date of service due to the fact that the screenings periodicity can range from every two months and up. See periodicity schedule at: http://www.la-kidmed.com/Forms/EducationalMaterials.aspx

6.6. Immunizations

6.6.1. The CCN shall provide all members under twenty-one (21) years of age with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.

6.6.2. The CCN shall ensure that all Providers use vaccines available without charge under the Vaccine for Children (VFC) Program for Medicaid children eighteen (18) years old and younger. Immunizations shall be given in conjunction with EPSDT/Well Child visits.

6.6.3. DHH will provide the CCN with immunization data for Medicaid CCN members through the month of their twenty-first (21st) birthday, who are enrolled in the CCN.

6.6.4. The CCN's providers shall report the required immunization data into the Louisiana Immunization Network for Kids (LINKS) administered by the DHH/Office of Public Health.

6.7. Emergency Medical Services and Post Stabilization Services

6.7.1. Emergency Medical Services

6.7.1.1. The CCN shall provide that emergency services be rendered without the requirement of prior authorization of any kind. The CCN must cover and pay for emergency services regardless of whether the provider that furnishes the emergency services has a contract with the CCN. If an emergency medical condition exists, the CCN is obligated to pay for the emergency service.

6.7.1.2. The CCN shall advise all Medicaid CCN members of the provisions governing in and out-of-service area use of emergency services as defined in the Glossary.

6.7.1.3. The CCN shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's PCP or CCN of the member's screening and treatment within ten (10) calendar days of presentation for emergency services.

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

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

6.7.1.6. The attending emergency physician or the provider actually treating the member shall determine when the member is sufficiently stabilized for transfer or discharge and that determination is binding on the CCN for coverage and payment.

6.7.1.7. If there is a disagreement between a hospital or other treating facility and a CCN concerning whether the member is stable enough for discharge or transfer from the emergency room, the judgment of the attending *emergency* physician(s) at the hospital or other treating facility at the time of discharge or transfer prevails and is binding on the CCN. This subsection shall not apply to a disagreement concerning discharge or transfer following an inpatient admission *once the member is stabilized*.

6.7.1.8. The CCN shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

6.7.1.9. The CCN shall be responsible for educating members and providers regarding appropriate utilization of emergency room services, including behavioral health emergencies.

6.7.1.10. The CCN shall monitor emergency services utilization (by both provider and member) and shall have guidelines for implementing corrective action for inappropriate utilization. For utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For the purposes of this contract, a prudent layperson is: a person who possesses an average knowledge of health and medicine.

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

6.7.2. Post Stabilization Services

6.7.2.1. As specified in 42 CFR §438.114(e) and 42 CFR §422.113(c)(2)(i), (ii) and (iii), the CCN is financially responsible (consistent with 42 CFR §422.214) for post-stabilization care services obtained within or outside the CCN that are:

6.7.2.1.1. Pre-approved by a network provider or other CCN representative; or

6.7.2.1.2. Not preapproved by a network provider or other CCN representative, but:

6.7.2.1.2.1. Administered to maintain the member's stabilized condition within one (1) hour of a request to the CCN for pre-approval of further post-stabilization care services;

6.7.2.1.2.2. Administered to maintain, improve or resolve the member's stabilized condition if the CCN:

- Does not respond to a request for pre-approval within one (1) hour;
- Cannot be contacted; or
- CCN's representative and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the CCN must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of Section 6.7.2.1.4.1 (422.133(c)(3)) is met.

6.7.2.1.3. The CCN's financial responsibility for post-stabilization care services that it has not pre-approved ends when:

6.7.2.1.3.1. A network physician with privileges at the treating hospital assumes responsibility for the member's care;

6.7.2.1.3.2. A network physician assumes responsibility for the member's care through transfer;

6.7.2.1.3.3. A representative of the CCN and the treating physician reach an agreement concerning the member's care; or

6.7.2.1.3.4. The member is discharged.

6.8. Emergency Ancillary Services Provided at the Hospital

Emergency ancillary services which are provided in a hospital include, but are not limited to, radiology, pathology, emergency medicine and anesthesiology. The CCN shall reimburse the professional component of these services at a rate equal to or greater than the published Medicaid fee-for-service rate in effect on the date of service to in-network providers when a CCN provider authorizes these services (either in-patient or out-patient). Emergency ancillary services rendered by non-network providers in a hospital setting shall be reimbursed at the published Medicaid fee schedule in effect on the date of service.

6.9. Prenatal Care Services

6.9.1. The CCN shall ensure its Medicaid members under its care who are pregnant, begin receiving care within the first trimester. (See Appendix J **Performance Measures**) The CCN shall provide available, accessible, and adequate numbers of PCPs and OB/GYN physicians to provide prenatal services to all members. As noted in the Women's Health Services subsection, the pregnant member shall be assured direct access within the CCN's provider network to routine OB/GYN services, and the OB/GYN shall notify the PCP of his/her provision of such care and shall coordinate that care with the PCP.

6.9.2. The CCN shall develop an effective outreach program to encourage women to seek prenatal services during the first trimester of pregnancy. This outreach program may utilize community and religious organizations and other community groups to develop outreach programs or referral networks, as well as include issuance of brochures and/or periodic articles emphasizing the importance of such care to all members.

6.9.3. The CCN shall conduct its own maternal and infant mortality reviews and shall routinely provide to DHH all requested information for qualified Infant Mortality Reviews (qualified Infant Mortality Reviews are confidential and non-discoverable) in the timeframes specified by DHH. Reviews shall be conducted in cooperation with DHH and the Louisiana Perinatal Care and Prevention of Infant Mortality Commission.

6.9.4. The CCN shall provide a risk assessment for all obstetrical patients and have available, accessible, and adequate maternal fetal medicine specialists for high-

risk obstetrical patients requiring further evaluation, consultation, or care and delivery as recommended by the American College of Obstetricians and Gynecologists, Guidelines for ***Perinatal Care, "Factors That May Increase Pregnancy Risks***". A pregnant woman is considered high-risk if one or more risk factors are indicated. The CCN shall provide case management for high-risk obstetrical patients.

6.9.5. The CCN shall ensure that the PCP or the OB provides prenatal care in accordance with the "***Prenatal Care Recommendations***" of the American College of Obstetricians and Gynecologists. The CCN shall ensure that the PCP or the OB counsels the pregnant member about plans for her child, such as designating the family practitioner or pediatrician who is to perform the newborn exam and choosing a PCP to provide subsequent pediatric care to the child once the child is added to the CCN as well as appropriate referrals to the WIC program for nutritional assistance. (See Appendix K – **WIC Referral Form**).

6.9.6. The CCN's network providers shall promote CMS's "Text 4 Baby" initiative, a free mobile health service that provides health information through SMS text messages to pregnant women and new mothers during their babies' first year. Information on the program is available at: www.text4baby.org. The CCN shall provide details of its plan in the CCN Marketing and Outreach Plan submitted to DHH for approval.

6.10. Maternity Services

Coverage for a hospital stay following a normal vaginal delivery may generally not be limited to less than 48 hours for both the mother and newborn child. Health coverage for a hospital stay in connection with childbirth following a cesarean section may generally not be limited to less than 96 hours for both mother and newborn child. Claim grouping to delivery procedures are the responsibility of the physical health provider regardless of primary or secondary mental health diagnosis appearing on the claim.

6.11. Family Planning Services

6.11.1. Family planning services are available to help prevent unintended or unplanned pregnancies. The CCN shall provide coverage for the following family planning services:

6.11.1.1. Medical history and physical exam;

6.11.1.2. Annual general physical assessment; non-prescriptive methods can be seen every two (2) years;

6.11.1.3. Laboratory test routinely performed as part of an initial or regular follow-up visit/exam for family planning purposes (PAP smear; Gonorrhea and Chlamydia testing; syphilis serology; HIV testing; and rubella titer);

6.11.1.4. Client education relative to reproductive anatomy and physiology, fertility regulation, and STD transmission;

6.11.1.5. Counseling to assist members in reaching an informed decision;

6.11.1.6. Method counseling; results of history and physical exam; mechanism of action, side effects and possible complications;

6.11.1.7. Special counseling (when indicated) regarding pregnancy planning and management; sterilization; genetics; nutrition; and

6.11.1.8. Pregnancy diagnosis, counseling and referral.

6.11.2. These services shall include any medically approved diagnostic evaluation, supplies, devices, and related counseling for the purpose of voluntarily preventing or delaying pregnancy or for the detection or treatment of sexually transmitted diseases (STDs).

6.11.3. Services are to be provided in a confidential manner to individuals of childbearing age including minors who may be sexually active, who voluntarily choose not to risk initial pregnancy, or wish to limit the number and spacing of their children.

6.11.4. 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).

6.11.5. The out-of-network Medicaid enrolled family planning services provider shall bill the CCN and be reimbursed no less than the Medicaid fee-for-service rate in effect on the date of service.

6.11.6. 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 a member's total care. No additional reimbursements shall be made to the CCN for CCN members who elect to receive family planning services outside the CCN's provider network.

6.11.7. The CCN shall encourage family planning providers to communicate with PCPs once any form of medical treatment is undertaken.

6.11.8. The CCN shall maintain accessibility for family planning services through promptness in scheduling appointments, particularly for teenagers.

6.11.9. The CCN shall make certain that payments from DHH are not utilized for the services for the treatment of infertility.

6.12. Hysterectomies

6.12.1. The CCN shall cover the cost of medically necessary hysterectomies as provided in 42 CFR §441.255 (2005, as amended).

6.12.2. Non-elective, medically necessary hysterectomies provided by the CCN shall meet the following requirements:

6.12.2.1. The individual or her representative, if any, must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing;

6.12.2.2. The individual or her representative, if any, must sign and date the **Acknowledgment of Receipt of Hysterectomy Information** form (See Appendix L) prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age.

6.12.2.2.1. The **Acknowledgment of Receipt of Hysterectomy Information** form is acceptable when signed after the surgery only if it clearly states that the patient was informed prior to the surgery that she would be rendered incapable of reproduction.

6.12.2.2.2. The **Acknowledgment of Receipt of Hysterectomy Information** form is not required if the individual was already sterile before the hysterectomy or if the individual required a hysterectomy because of a life threatening emergency situation in which the physician determined that prior acknowledgment was not possible. In these circumstances, a physician statement is required.

6.12.3. Hysterectomy shall not be covered if performed solely for the purpose of rendering an individual permanently incapable of reproducing.

6.12.4. Hysterectomy shall not be covered if there was more than one purpose for performing the hysterectomy, but the primary purpose was to render the individual permanently incapable of reproducing.

6.13. Sterilization

6.13.1. Sterilization is defined as any medical treatment or procedure that renders an individual permanently incapable of reproducing. Federal regulations contained in 42 CFR §§441.250 - 441.259 require that a consent form be completed before a sterilization procedure can be performed

6.13.2. Non-therapeutic sterilization must be documented with a completed **Sterilization Consent Form** (See Appendix M) which will satisfy federal and state regulations. Sterilization requirements include the following:

6.13.2.1. Sterilization shall mean any medical procedure, treatment or operation done for the purpose of rendering an individual permanently incapable of reproducing.

6.13.2.2. The individual to be sterilized shall give informed consent not less than thirty (30) full calendar days (or not less than 72 hours in the case of premature delivery or emergency abdominal surgery) but not more than one hundred eighty (180) calendar days before the date of the sterilization. A new consent form is required if 180 days have passed before the surgery is provided.

6.13.2.3. The consent for sterilization cannot be obtained while the patient is in the hospital for labor, childbirth, abortion or under the influence of alcohol or other substances that affects the patient's state of awareness.

6.13.2.4. The individual to be sterilized is at least twenty-one (21) years old at the time consent is obtained.

6.13.2.5. The individual to be sterilized is mentally competent.

6.13.2.6. The individual to be sterilized is not institutionalized: *i.e*., not involuntarily confined or detained under a civil or criminal status in a correctional or rehabilitative facility or confined in a mental hospital or other facility for the care and treatment of mental illness, whether voluntarily or involuntarily committed.

6.13.2.7. The individual has voluntarily given informed consent on the approved **Sterilization Consent Form**.

6.14. Limitations on Abortions

6.14.1. Abortions must be prior approved before the service is rendered to ensure compliance with federal and state regulations.

6.14.2. The CCN shall provide for abortions in accordance with 42 CFR §441. 200 *et seq* Subpart E and the requirements of the Hyde Amendment (Departments of Labor, Hospitals, Education, and Related Agencies Appropriations Act, 1998, Public Law 105-78, §§ 509 and 510) and only if:

6.14.2.1. 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; or

6.14.2.2. The pregnancy is the result of an act of rape or incest.

6.14.3. For abortion services performed because of Section § 6.15.2.1, a physician must certify in their handwriting, that on the basis of their professional judgment, the life of the pregnant woman would be endangered if the fetus were carried to term. The provider shall:

6.14.3.1. Attach the certification statement to the claim form that shall be retained by the CCN. The certification statement shall contain the name and address of the patient. The diagnosis or medical condition which makes the pregnancy life endangering shall be specified on the claim.

6.14.4. In the case of terminating a pregnancy as the result of an act of rape or incest the following requirements shall be met:

6.14.4.1. The member shall report the act of rape or incest to a law enforcement official unless the treating physician certifies in writing that in the physician's professional opinion, the victim was too physically or psychologically incapacitated to report the rape or incest;

6.14.4.2. The report of the act of rape or incest to law enforcement official or the treating physician's statement that the victim was too physically or psychologically incapacitated to report the rape or incest shall be

submitted to the CCN along with the treating physician's claim for reimbursement for performing an abortion;

6.14.4.3. The member shall certify that the pregnancy is the result of rape or incest and this certification shall be witnessed by the treating physician; and

6.14.4.4. The **Certification of Informed Consent--Abortion**, which must be obtained from the Louisiana Office of Public Health (Appendix N) shall be witnessed by the treating physician. Providers shall attach a copy of the **Certification of Informed Consent--Abortion** form to their claim form. All claim forms and attachments shall be retained by the CCN.

6.14.5. The CCN shall forward a copy of the claim and its accompanying documentation to DHH. Or in the case of terminating a pregnancy due to rape or incest the following requirements shall be met:

6.14.5.1. The Medicaid member shall report the act of rape or incest to a law enforcement official unless the treating physician certifies in writing that in the physician's professional opinion, the victim was too physically or psychologically incapacitated to report the rape or incest.

6.14.5.2. The report of the act of rape or incest to a law enforcement official or the treating physician's statement that the victim was too physically or psychologically incapacitated to report the rape or incest shall be submitted to DHH along with the treating physician's claim for reimbursement for performing an abortion.

6.14.5.3. The Medicaid member shall certify that the pregnancy is the result of rape or incest and this certification shall be witnessed by the treating physician.

6.14.5.4. The **Certification of Informed Consent-Abortion** form shall be witnessed by the treating physician.

6.14.6. No other abortions, regardless of funding, can be provided as a benefit under this Contract.

6.14.7. The CCN shall not make payment for any core benefit or service under the Contract to a network or non-network provider if any abortion performed hereunder violates federal regulations (Hyde Amendment).

6.15. Institutional Long-Term Care Facilities/Nursing Homes

6.15.1. The CCN is not responsible for any institutional long-term care facility/nursing home services. All such services shall continue to be reimbursed as fee-for-service. Any CCN member transitioned to a nursing home level of care will be disenrolled from the CCN at the earliest effective date allowed by system edits.

6.15.2. The CCN is responsible for all core benefits and services as long as a member is enrolled in the CCN, including periods in which the member is admitted to a long-term care facility/nursing home for rehabilitative purposes and prior to the time the member is disenrolled from the CCN.

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6.16. Medical Services for Special Populations

6.16.1. Special health care needs population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches.

6.16.2. The CCN shall identify members with special health care needs within ninety-(90) days of receiving the member's historical claims data (if available). 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 as appropriate shall result in a referral for case management.

During the initial phase-in implementation of the CCN Program, DHH will extend the identification timeframe requirement to one hundred eighty (180) days from the enrollment effective date.

6.16.3. The mechanisms for identifying members with special health care needs (SHCN) that require an assessment to determine if a course of treatment or regular care monitoring is needed are as follows:

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

6.16.3.2. CCN PCPs shall identify to the CCN those members who meet SHCN criteria.

6.16.3.3. Members may self identify to either the Enrollment Broker or the CCN that they have special health care needs. The Enrollment Broker will provide notification to the CCN of members who indicate they have special health care needs.

6.16.4. Individualized Treatment Plans

The individualized treatment plans must be:

6.16.4.1. Developed by the members PCP, with enrollee participation, and in consultation with any specialists caring for the member;

6.16.4.2. Approved by the CCN in a timely manner if required by the CCN; and

6.16.4.3. In compliance with applicable QA and UM standards.

6.17. DME, Prosthetics, Orthotics, and Certain Supplies (DMEPOS)

The CCN shall provide coverage of medically necessary durable medical equipment, prosthetics, orthotics, certain supplies, appliances, and assistive devices including, but not limited to, hearing aids for members under the age of 21. DME for those under 21

includes disposable incontinence supplies and enteral formula The CCN shall provide and be financially responsible for any DMEPOS item that is medically necessary for members under the under the age of 21.

6.18. Women, Infant, and Children (WIC) Program Referral

The CCN shall be responsible for ensuring that coordination exists between the WIC Program and CCN providers. Coordination shall include referral of potentially eligible women, infants and children and reporting of appropriate medical information to the WIC Program. The DHH Office of Public Health administers the WIC Program. A sample referral/release of information form is found in Appendix K

6.19. Preventative and Safety Educational Programs/Activities

The CCN may provide healthy lifestyle educational programs/activities for the whole family which may include, for example, a discount to a local fitness facility, web access to a healthy cooking website, weight management program participation and/or a smoking cessation program. The CCN shall obtain approval from DHH prior to implementation of any such program.

6.20. Medical Transportation Services

6.20.1. The CCN shall provide emergency and non-emergency medical transportation for its members. Non-emergency medical transportation shall be provided to members who lack transportation to and from services covered by the Contract. Non-emergency medical transportation to access carved out services will not be the financial responsibility of the CCN.

6.20.2. The CCN may establish its own policy for medical transportation services as long as the CCN ensures members' access to care and the CCN's policy is in accordance with current Louisiana Medicaid guidelines for non-emergency and emergency medical transportation (such as whether the member owns a vehicle or can access transportation by friends, relatives or public transit).

6.21. Excluded Services

6.21.1. Excluded services shall be defined as those services that members may obtain under the Louisiana State Plan, and for which the CCN is not financially responsible. However the CCN is responsible for informing members on how to access excluded services, providing all required referrals and assisting in the coordination of scheduling such services. These services shall be paid for by DHH on a fee-for-service basis or other basis. Services include the following:

6.21.1.1. Services provided through DHH's Early Steps Program;

6.21.1.2. Dental;

6.21.1.3. Hospice

6.21.1.4. ICF/DD Services;

6.21.1.5. Personal Care Services;

6.21.1.6. Nursing Facility Services;

6.21.1.7. Pharmacy Services (Prescription Medicines Dispensed)

6.21.1.8. Individualized Education Plan (IEP) Services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures (these services are not provided by OPH certified school-based health clinics);

6.21.1.9. All Home & Community-Based Waiver Services;

6.21.1.10. Specialized Behavioral Health;

6.21.1.11. Targeted Case Management Services including Nurse Family Partnership:

6.21.1.12. Services provided through DHH's Early-Steps Program (Individuals with Disabilities Education Act (IDEA) Part C Program Services);

6.21.2. DHH shall have the right to add excluded services into CCN core benefits and services at a later date.

6.22. Prohibited Services

6.22.1. Elective abortions (those not covered in Section § 6.14) and related services;

6.22.2. Experimental/investigational drugs, procedures or equipment, unless approved by the Secretary of DHH;

6.22.3. Elective cosmetic surger, and

6.22.4. Services for treatment of infertility.

6.23. Expanded Services/Benefits

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

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

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

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

6.23.5. The CCN shall provide DHH a description of the expanded services/benefits to be offered by the CCN for approval. Additions, deletions or modifications to

expanded services/benefits made during the contract period must be submitted to DHH, for approval.

6.24. Care Management

6.24.1. Care management is defined as the overall system of medical management, care coordination, continuity of care, care transition, chronic care management, quality 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 covered services provided to the member.

6.24.2. The CCN shall be responsible for ensuring:

6.24.2.1. Member's health care needs and services/care are planned and coordinated through the CCN PCP;

6.24.2.2. 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 hour availability of information, referral, and treatment for emergency medical conditions; and

6.24.2.3. Care coordination and referral activities incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical and/or behavioral health services.

6.25. Referral System for Specialty Healthcare

6.25.1. 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 of CCN members to specialty 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 and out-of-network referrals, services (*e.g.*, medications prescribed, treatment received, recommendations for care), and follow up are included in the PCP's member medical record.

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

6.25.2.1. When a referral from the member's PCP is and is not required (See Section §8.5.1.6 Exceptions to Service Authorization and/or Referral Requirements);

6.25.2.2. Process for member referral to an out-of-network provider when there is no provider within the CCN's provider network who has the appropriate training or expertise to meet the particular health needs of the member;

6.25.2.3. Process for providing a standing referral when a member with a condition requires on-going care from a specialist;

6.25.2.4. 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;

6.25.2.5. Process for member referral for case management;

6.25.2.6. Process for member referral for chronic care management;

6.25.2.7. Policy that prohibits providers from making referrals for designated health services to healthcare entities with which the provider or a member of the provider's family has a financial relationship.

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

6.25.2.9. 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

6.25.2.10. Process for referral of members for Medicaid State Plan services that are excluded from CCN core benefits and services and that will continue to be provided through fee-for-service Medicaid.

6.25.2.11. 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.

6.26. Care Coordination, Continuity of Care, and Care Transition

6.26.1. The CCN shall develop and maintain effective care coordination, continuity of care, and care transition activities to 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 core benefits and services with services that are reimbursed on a fee-for-service basis 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.

6.26.2. The CCN shall be responsible for the coordination and continuity of care of healthcare services for all members consistent with 42 CFR §438.208.

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

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

6.26.3.2. Coordinate care between PCPs and specialists;

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

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

6.26.3.5. 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;

6.26.3.6. 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, and other applicable state or federal laws;

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

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

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

6.26.3.10. Document authorized referrals in its utilization management system; and

6.26.3.11. 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;

6.27. Continuity of Care for Pregnant Women

6.27.1. In the event a Medicaid 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 be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The CCN shall provide continuation 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.

6.27.2. In the event a Medicaid eligible entering the CCN is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before CCN enrollment, the CCN shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider until such time as the CCN can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health.

6.27.3. In the event a Medicaid 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, the CCN shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract provider) through the postpartum period.

6.27.4. The contract shall ensure that the member is held harmless by the provider for the costs of medically necessary core benefits and services.

6.28. Preconception/Inter-conception Care

For fertile women of reproductive age, the woman's plan for future pregnancy shall be discussed on an annual basis during routine gynecological care. Appropriate family planning and/or health services shall be provided based on the patient's desire for future pregnancy and shall assist the patient in achieving her plan with optimization of health status in the interim.

6.29. Continuity of Care for Individuals with Special Health Care Needs

6.29.1. 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.

6.30. Continuity for Behavioral Health Care

6.30.1. 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.

6.30.2. In order to ensure continuity and coordination of care for members who appear to need 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.

6.30.3. 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. Payment for the emergency service is the responsibility of the CCN.

6.30.4. The CCN shall comply with all post stabilization care service requirements found at 42 CFR §422.113.

6.30.5. 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.

6.30.6. 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.

6.30.7. 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.

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

6.31. Continuity for DME, Prosthetics, Orthotics, and Certain Supplies

In the event a Medicaid member entering the CCN is receiving Medicaid covered durable medical equipment, prosthetics, orthotics, and certain supplies services the day before CCN enrollment, whether such services were provided by another CCN or Medicaid fee-for-service, the CCN shall be responsible for the costs of continuation of these services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The CCN shall provide continuation of such services for up to thirty (30) calendar

days **or** until the member may be reasonably transferred (within timeframe specified in this RFP) without disruption, whichever is less. The CCN must also honor any prior authorization for durable medical equipment, prosthetics, orthotics and certain supplies services issued while the member was enrolled in another CCN or the Medicaid fee-for-service program for a period of thirty (30) calendar days after the member's enrollment in the CCN.

6.32. Care Transition

6.32.1. Provide active assistance to members when transitioning to another provider (CCN, or Medicaid FFS).

6.32.2. 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 (i.e. prenatal care, acute care, etc.). 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, but not limited to, 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.

6.32.3. 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 of the beginning of the month that the new CCN member enrollment is effective.

6.32.4. 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.

6.32.5. 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.

6.32.6. 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.

6.32.7. 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.

6.32.8. Special consideration should be given to, but not limited to, the following:

6.32.8.1. .Members with significant conditions or treatments such as enteral feedings, oxygen, wound care, and ventilators, medical supplies, transportation on a scheduled basis, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition;

6.32.8.2. Members who have received prior authorization for services such as scheduled surgeries, post surgical follow up visits, therapies to be provided after transition or out-of-area specialty services;

6.32.8.3. Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the NICU after birth;

6.32.8.4. Members with significant medical conditions such as a high-risk pregnancy or pregnancy within the last 30 days, the need for organ or tissue transplantation, chronic illness resulting in hospitalization;

6.32.9. 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.

6.33. Case Management

6.33.1. 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, social services, and basic 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, social and behavioral health needs of the member. The CCN shall submit case management program policies and procedures to DHH for approval within thirty (30) days following the date the contract is signed and annually thereafter.

6.33.2. Case Management program functions shall include but not be limited to:

6.33.2.1. Early identification of members who have or may have special needs;

6.33.2.2. Assessment of a member's risk factors;

6.33.2.3. Education regarding Patient-Centered Medical Home and referral to a Medical Home when appropriate;

6.33.2.4. Development of an individualized treatment 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

6.33.2.5. Referrals and assistance to ensure timely access to providers;

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

6.33.2.7. Monitoring;

6.33.2.8. Continuity of care; and

6.33.2.9. Follow-up and documentation.

6.34. Case Management Policies and Procedures

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

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

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

6.34.3. 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;

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

6.34.5. Procedures and criteria for making referrals to specialists and subspecialists;

6.34.6. Procedures and criteria for maintaining care plans and referral services when the member changes PCPs; and

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

6.35. 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 due date of those reports. The case management reports shall include at a minimum:

6.35.1. Number of members identified with potential special healthcare needs utilizing historical claims data;

6.35.2. Number of members with special healthcare needs identified by the member's PCP;

6.35.3. Number of members with assessments;

6.35.4. Number of treatment plans completed, and

6.35.5. Number of members with assessments resulting in a referral for Case Management.

6.36. Chronic Care Management Program (CCMP)

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

6.36.1.1. Asthma;

6.36.1.2. Diabetes; and

6.36.1.3. Congestive heart failure.

6.36.2. 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.

6.36.3. The CCN shall submit Chronic Care Management Program policies and procedures to DHH for approval within thirty (30) days of signing the Contract, annually and previous to any revisions. The CCN shall develop and implement policies and procedures that:

6.36.3.1. Include the definition of the target population;

6.36.3.2. Include member identification strategies;

6.36.3.3. Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;

6.36.3.4. Include guidelines for treatment plan development, as described in NCQA Disease Management program content, that provide the outline for all program activities and interventions;

6.36.3.5. Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions;

6.36.3.6. Include methods for informing and educating members and providers;

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

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

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

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

6.36.3.11. Include Program Evaluation requirements.

6.37. Predictive Modeling

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

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

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

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

6.37.2.3. Assessments of data reliability and model validity;

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

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

6.38. CCMP Reporting Requirements

6.38.1. 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.

6.38.2. The CCMP reports shall contain at a minimum:

6.38.2.1. Total number of members;

6.38.2.2. Number of members in each stratification level for each chronic condition; and

6.38.2.3. Number of members who were disenrolled from program and explanation as to why they were disenrolled.

6.38.3. The CCN shall submit the following report annually:

6.38.3.1. Program evaluation

6.39. Care Transition

6.39.1.1. The CCN shall provide active assistance to members when transitioning to another provider (CCN, or Medicaid FFS).

6.39.1.2. 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 (i.e. prenatal care, acute care, etc.). 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, but not limited to, 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.

6.39.1.3. 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.

6.39.1.4. 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.

6.39.1.5. 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.

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7.0 PROVIDER NETWORK REQUIREMENTS

7.1. General Provider Network Requirements

7.1.1. The CCN must maintain a network of qualified providers in sufficient numbers and locations within the GSA, including parishes contiguous to the GSA, to provide required access to covered services. 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. The CCN shall design their provider networks to maximize the availability of community based primary care and specialty care access and that reduces utilization of emergency services, one day hospital admissions, hospital based outpatient surgeries when lower cost surgery centers are available, eliminates preventable hospital readmissions, and hospitalization for preventable medical problems.

7.1.2. The CCN must provide a comprehensive network to ensure its membership has access at least equal to, or better, than community norms. Services shall be accessible to 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 [42 CFR 438.210.(a)(2)]. 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 shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR 438.206(b)(4) and (5)].

7.1.3. There shall be sufficient personnel for the provision of all covered services, including emergency medical care on a 24-hour-a-day, 7-day-a-week basis.

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

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

7.1.6. If a current Medicaid provider requests participation in a CCN, the CCN shall make a good faith effort to execute a contract. In the event an agreement cannot be reached and the provider does not participate in the CCN, the CCN has met this requirement; the CCN shall maintain documentation detailing efforts made.

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

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

7.1.9. The CCN shall make a good faith effort to execute a contract with significant traditional providers (STPs). In the event an agreement cannot be reached and a STP does not participate in the CCN, the CCN shall maintain documentation detailing efforts that were made.

7.1.10. The CCN must offer a Contract to the following providers:

- Louisiana Office of Public Health (OPH);
- All OPH-certified School Based Health Clinics (SBHCs) in the GSA;
- All small rural hospitals in the GSA meeting the definition in the Rural Hospital Preservation Act of 1997;
- Federally Qualified Health Centers (FQHCs);
- Rural Health Clinics (RHCs) (free-standing and hospital based); and
- Louisiana State University safety net hospitals.

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

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

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

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

7.1.15. The CCN shall meet the following requirements:

7.1.15.1. Ensure the provision of all core benefits and services specified in the Contract. Accessibility of benefits/services, including geographic access, appointments, and wait times shall be in accordance with the requirements in this RFP. These minimum requirements are not intended to release the CCN from the requirement to provide or arrange for the provision of any

medically necessary covered benefit/service required by its members, whether specified or not.

7.1.15.2. Provide core services directly or enter into written agreements with providers or organizations that shall provide core services to the members in exchange for payment by the CCN for services rendered. CCN in and out-of-network providers shall be eligible to enroll as Louisiana Medicaid providers.

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

7.1.15.4. Ensure that CCN PCP's maintain hospital admitting privileges or that they have arrangements with a physician who has admitting privileges at a CCN participating hospital.

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

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

7.1.15.6. If the CCN is unable to meet the geographic access standards for a member, the CCN must make transportation available to the member, regardless of whether the member has access to transportation.

7.1.15.7. Monitor provider compliance with applicable access requirements, including but not limited to, appointment and wait times, and take corrective action for failure to comply. The CCN shall conduct service area review of appointment availability and twenty-four (24) hour access and availability surveys annually. The survey results must be kept on file and be readily available for review by DHH upon request.

7.1.15.8. If a member requests a CCN provider who is located beyond access standards, and the CCN has an appropriate provider within the CCN who

accepts new patients, it shall not be considered a violation of the access requirements for the CCN to grant the member's request. However, in such cases the CCN shall not be responsible for providing transportation for the member to access care from this selected provider, and the CCN shall notify the member in writing as to whether or not the CCN will provide transportation to seek care from the requested provider.

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

7.1.15.10. 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. Failure to do so may result in monetary penalties up to $5,000 per day against the CCN.

7.2. Mainstreaming

7.2.1. 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.

7.2.2. 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:

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

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

7.2.2.3. 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.

7.2.3. 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.

7.3. Access Standards and Guidelines

The CCN shall ensure access to health care services (distance traveled, waiting time, length of time to obtain an appointment, after-hours care) in accordance with the provision of services under this RFP. DHH will monitor the CCN's service accessibility. The CCN shall provide available, accessible and adequate numbers of institutional facilities, service locations, service sites, and professional, allied and para-medical personnel for the provision of core benefits and services, including all emergency services, and shall take corrective action if there is failure to comply by any provider. At a minimum, this shall include:

7.3.1. Twenty-four (24) Hour Coverage

The CCN shall ensure that all emergency medical care is available on a twenty-four (24) hours a day, seven (7) days a week basis through its network providers, and shall maintain, twenty-four (24) hours per day, seven (7) days per week telephone coverage to instruct CCN members on where to receive emergency and urgent health care. The CCN may elect to provide 24 hour coverage by direct access or through arrangement with a triage system. Any triage system arrangement must be prior approved by DHH.

7.3.2. 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.

7.3.2.1. Time and Distance to Primary Care Providers

7.3.2.1.1. Travel distance for members living in rural parishes shall not exceed 30 miles; and

7.3.2.1.2. Travel distance for members living in urban parishes shall not exceed 10 miles

7.3.2.2. Time and Distance to Hospitals

7.3.2.2.1. For urban areas, within thirty (30) minutes of a member's residence; and

7.3.2.2.2. For rural areas, within thirty (30) miles. If no hospital is available within thirty (30) miles of a member's residence, the CCN may request, in writing, an exception to this requirement.

7.3.2.3. Time and Distance to Specialists

7.3.2.3.1. Travel distance shall not exceed sixty (60) miles for at least 75% of members; and

7.3.2.3.2. Travel distance shall not exceed ninety (90) miles for all members.

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

7.3.2.4. Time and Distance to Lab and Radiology Services

7.3.2.4.1. Travel distance shall not exceed thirty (30) minutes or thirty (30) miles; and

7.3.2.4.2. For rural areas, exceptions for community standards shall be justified, documented and submitted to DHH for approval.

7.3.2.4.3. Other medical service providers participating in the CCN's network also must be geographically accessible to CCN members as outlined in this RFP.

7.4. Scheduling/Appointment Waiting Times

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

7.4.2. 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.

7.5. Timely Access

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

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

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

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

7.5.4. Maternity Care

Initial appointment for prenatal visits for newly enrolled pregnant women shall meet 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 within seven (7) days;
- Within their third trimester within three (3) days;
- 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;

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

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

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

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

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

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

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

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

7.5.12. The CCN shall establish processes to monitor and reduce the appointment "no-show" rate for PCPs, and transportation providers. As best practices are identified, DHH may require implementation by the CCN.

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

7.6. Assurance of Adequate PCP Access and Capacity

7.6.1. The PCP shall serve as the member's initial and most important point of interaction with the CCN's provider network. A PCP in the CCN must be a provider who provides or arranges for the delivery of medical services, including case management, to assure that all services, which are found to be medically necessary, are made available in a timely manner as outlined in this Section.

7.6.2. The PCP may practice in a solo or group practice or may practice in a clinic (i.e. Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)) or outpatient clinic. The CCN shall provide at least one (1) full time equivalent (FTE) PCP per two thousand, five hundred (2,500) CCN members. 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. The CCN shall require that each individual PCP shall not exceed a total of two thousand, five hundred (2,500) Medicaid linkages in all CCN's in which the PCP may be a network provider. The PCP to Medicaid member patient ratio (inclusive of all CCN members) shall not exceed the following unless approved by DHH:

- Physician (Family Practice, General Practice, Pediatric, OB/GYN) – 1: up to 2,500
- Nurse Practitioner : 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.

7.6.3. The CCN may submit a request for an exception to the PCP-to-patient ratio to DHH for approval.

7.6.4. 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.

7.6.5. 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].

7.6.6. 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.

7.6.7. 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.

7.7. Primary Care Provider Responsibilities

PCP responsibilities shall include, but are not be limited to:

7.7.1. Managing the medical and health care needs of members to assure that all medically necessary services are made available in a timely manner;

7.7.2. Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services available through fee-for-service Medicaid. Coordination shall include but not be limited to:

7.7.2.1. Referring patients to subspecialists and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available; and

7.7.2.2. Communicate with other levels of care (primary care, specialty outpatient care, emergency and inpatient care) to coordinate, and follow up the care of individual patients.

- Provide the level of care and range of services necessary to meet the medical needs of its members, including those with special needs and chronic conditions,
- Monitoring and follow-up of care provided by other medical service providers for diagnosis and treatment, to include services available under Medicaid FFS;
- Maintaining a medical record of all services rendered by the PCP and other referral providers; and
- Coordinating case management services to include, but not be limited to, performing screening and assessment, development of plan of care to address risks and medical needs and other responsibilities as defined in Section 6.32.
- Coordinate the services the CCN furnishes to the member with the services the member receives from any another CCN during transition of care.
- Share the results of identification and assessment of any member with special health care needs (as defined by DHH) with another

CCN to which a member may be transitioning or has transitioned so that those activities need not be duplicated.

- To ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information and all state statutes.

7.7.2.3. Examples of Acceptable PCP After-Hours Coverage

- The PCP's office telephone is answered after-hours by an answering service that 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.

7.7.2.4. Examples of Unacceptable PCP After Hours Coverage

- The PCP's office telephone is only answered during office hours;

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

- The PCP's 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.

7.7.3. Access to Specialty Providers

7.7.3.1. The CCN shall assure access to specialty providers, as appropriate, for all members. The CCN shall assure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area. The CCN provider network shall include participating specialists with pediatric expertise for children/adolescents when the need for pediatric specialty care is significantly different from the need for adult specialty care (e.g. a pediatric cardiologist). The CCN shall ensure access to appropriate service settings for members needing

medically high risk perinatal care, including both prenatal and neonatal care,

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

- The CCN has signed a contract with providers of the specialty types listed below who accept new members and are available on at least a referral basis; and

- The CCN is in compliance with access and availability requirements.

7.7.3.3. The CCN shall assure, at a minimum, the availability of the following specialists and other providers, as appropriate for both adults and pediatric members, on at least a referral basis:

- Allergy/Immunology
- Anesthesiology
- Chiropractic
- Dermatology
- Electro-diagnostic Medicine
- Emergency Medicine
- Family Medicine (General)
- Internal Medicine (General)
    - Internal Medicine (Subspecialties)
    - Cardiovascular Disease*
    - Endocrinology and Metabolism*
    - Gastroenterology
    - Hematology
    - Infectious Disease
    - Medical Oncology
    - Nephrology*
    - Pediatrics
    - Pulmonary Disease
    - Rheumatology
    - Geriatric Medicine
    - Intensive Critical Care
- Medical Genetics
- Nephrology
- Neurology
    - Neurology-Surgical
    - Nuclear Medicine
- Obstetrics/Gynecology
    - Maternal and Fetal Medicine
- Oncology
- Ophthalmology
- Optometry
- Orthopedics*

- Osteopathy
- Otolaryngology
- Pathology
- Pediatric (General)
- Pediatric (Subspecialties)
- Cardiology
- Hematology/Oncology
- Internal Medicine
- Nephrology
- Neonatal Medicine
- Endocrinology
- Pulmonology
- Gastroenterology
- Intensive Critical Care
    - Adolescent Medicine
    - Physical Medicine and Rehabilitation
    - Psychiatry (as deemed necessary by the CCN)
    - Radiology
    - Respiratory/Pulmonary
- Medical Services
- Surgery (General)
- Surgery (Subspecialties)
    - Cardiac/Thoracic
    - Plastic (limited)
    - Pediatric
    - Vascular Surgery (General)
    - Surgery of the Hand
    - Surgical Critical Care

NOTE: Specialties above with an asterisk (*) require both adult and pediatric providers.

7.7.3.4. The CCN shall meet standards for timely access to all specialists and ensure that the number of CCN members per specialist does not exceed the following in each of the CCN's GSAs. The following provider/member ratios are the minimum the CCN must provide. The CCN will be required to provide a higher ratio of specialists per member population and/or additional specialist types/member ratios may be established, if it is determined by DHH the CCN does not meet the access standards (e.g. scheduling of appointment, timely access, time and travel distance requirements) specified in the Contract.

Maximum Number of Members per Provider by Specialty

Specialty	**Number of Members**
Allergy & Immunology	100,000
Cardiology	20,000

Dermatology	40,000
Endocrinology	25,000
Gastroenterology	30,000
General Surgery	15,000
Nephrology	50,000
Neurosurgery	45,000
Oncology/Hematology	80,000
Ophthalmology	20,000
Orthopedic Surgery	15,000
Otolaryngology	30,000
Urology	30,000

7.7.4. Access to Home Health Agencies

The CCN shall comply with any applicable federal requirements with respect to home health agencies, as amended.

7.7.5. Access to Hospitals

7.7.5.1. Hospital services providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in this RFP.

7.7.5.2. The CCN shall include, at a minimum, access to the following:

- One (1) hospital that provides emergency room services, inpatient, and outpatient care in each parish in the GSA, provided the parish has such a hospital.

- Essential hospital services for:

    - Level III Obstetrical services;
    - Level III Neonatal Intensive Care (NICU) services;
    - Pediatric services;
    - Trauma services;
    - Burn services; and

- A Children's Hospital that meets the CMS definition in 42CFR, Parts 412 and 413

7.7.5.3. The CCN may contract with out-of-state hospitals in the trade area.

7.7.5.4. The CCN may contract with out-of-state hospitals to comply with these requirements if there are no hospitals within the parish that meet these requirements or a contract cannot be negotiated.

7.7.6. Tertiary Care

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

7.7.7. Direct Access to Women's Health Care

The CCN shall provide direct access to a health specialist(s) in-network for core benefits and services necessary to provide women's routine and preventive health care services. This access shall be in addition to the member's PCP if that provider is not a women's health specialist.

7.7.7.1. 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 and interconception 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 this RFP;

7.7.7.2. 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 shall bill the CCN and be reimbursed no less than the Medicaid rate in effect on the date of service. 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. No additional reimbursements shall be made to the CCN for CCN members who elect to receive family planning services outside the CCN's provider network;

7.7.7.3. The CCN shall make a reasonable effort to contract with all local family planning clinics and providers, including those funded by Title X of the

Public Health Services Act, and shall reimburse providers for all family planning services regardless of whether that provider is a network provider no less than the Medicaid fee-for-service rate on date of service;

7.7.7.4. Reimbursement to out-of-network providers of family planning services for members shall be no less than the Medicaid fee-for-service rate on date of service. The CCN may require family planning providers to submit claims or reports in specified formats before reimbursing services; and

7.7.7.5. The CCN shall maintain the confidentiality of family planning information and records for each individual member including those of minor patients.

7.7.8. Prenatal Care Services

7.7.8.1. The CCN shall have a sufficient number of providers to ensure that prenatal care services are not delayed or denied to pregnant women.

7.7.8.2. Regardless of whether prenatal care is provided by a PCP, physician extender or an obstetrician who is not the member's PCP, the access standards for PCP services shall apply when determining access to prenatal care except for cases of a first prenatal care appointment for women who are past their first trimester of pregnancy on the day they are determined to be eligible for Louisiana Medicaid. For women who are past their first trimester of pregnancy on the first day they are determined to be eligible, a first prenatal appointment shall be scheduled as required in Section §7.3.4.4.

7.7.8.3. All pregnant members should choose a pediatrician, or other appropriate PCP, for the care of their newborn baby before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, the CCN shall assign one. If the CCN was not aware that the member was pregnant until she presented for delivery, the CCN shall assign a pediatrician or a PCP to the newborn baby within one (1) business day after birth.

7.7.9. Other Service Providers

The CCN shall ensure the availability of medical service providers including, but not limited to, ambulance services, durable medical equipment, orthotics, prosthetics and certain supplies, and radiology, and laboratories. All services must be provided in accordance with applicable state and federal laws and regulations.

7.7.10. Non-Emergency Medical Transportation

For medically necessary non-emergent transportation requested by the member or someone on behalf of the member, the CCN shall require its transportation provider to schedule the transportation so that the member arrives on time but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment.

7.7.11. FQHC/RHC Clinic Services

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

7.7.11.2. If a CCN is unable to contract with an FQHC or RHC within the geographic service area and PCP time and distance travel standards, (Section § 7.3.2.1) the CCN is not required to reimburse that FQHC or RHC for out-of-network services if FQHC or RHC services within Time and Distance to Primary Care Standards are available in that area unless:

7.7.11.2.1. The medically necessary services are required to treat an emergency medical condition; or

7.7.11.2.2. FQHC/RHC services are not available through CCNs (CCN-P or CCN-S) in the GSA within DHH's established time and distance travel standards.

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

7.7.11.4. While CCNs are not, in general, financially responsible for specialty behavioral health services, CCNs are responsible for all behavioral health services provided at FQHCs/RHCs.

7.7.11.5. The CCN shall inform members of these rights in their member handbooks.

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

7.7.12. School-Based Health Clinics (SBHCs)

7.7.12.1. 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.

7.7.12.2. The CCN must offer a contract to each SBHC in their GSA. The CCN may stipulate that the SBHC follow all of the CCN's required policies and procedures.

7.7.13. Local Parish Health Clinics

7.7.13.1. The CCN must offer a contract to the Louisiana Office of Public Health (OPH) for the provision of personal health services offered within the parish health units (e.g. immunizations, STD, family planning).

7.7.13.2. The CCN shall coordinate its public health-related activities with OPH. Coordination mechanisms and operational protocols for addressing public health issues shall 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.

7.7.14. Significant Traditional Providers

7.7.14.1. 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 that the STP:

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

7.7.14.2. Provider types/classes eligible for participation as a STP are:

- Physicians
- PCPs (as defined in Section 7.4.1.2);
- OB-GYNs, and
- Hospitals

7.8. Network Provider Development Management Plan

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

7.8.1.1. Anticipated maximum number of Medicaid members;

7.8.1.2. Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the CCN;

7.8.1.3. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core benefits and services;

7.8.1.4. The numbers of CCN providers who are not accepting new CCN members; and

7.8.1.5. The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and

whether the location provides physical access for Medicaid enrollees with disabilities.

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

7.8.2.1. Assurance of Adequate Capacity and Services

7.8.2.2. Access to Primary Care Providers

7.8.2.3. Access to Specialists

7.8.2.4. Access to Hospitals

7.8.2.5. Timely Access

7.8.2.6. Service Area

7.8.2.7. Other Access Requirements

- Direct Access to Women's Health
- Special Conditions for Prenatal Providers
- Second Opinion
- Out-of-Network Providers

7.8.3. 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.

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

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

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

7.8.5.2. 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;

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

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

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

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

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

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

7.8.5.9. Ensure that provider calls are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 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.

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

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

7.9. Material Change to Provider Network

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

7.9.1.1. Any change that would cause more than five percent (5%) of members in the GSA to change the location where services are received or rendered.

7.9.1.2. A decrease in the total of individual PCPs by more than five percent (5%);

7.9.1.3. A loss of any participating specialist which may impair or deny the members' adequate access to providers;

7.9.1.4. A loss of a hospital in an area where another CCN hospital of equal service ability is not available as required by access standards specified in this RFP; or

7.9.1.5. Other adverse changes to the composition of the CCN which impair or deny the members' adequate access to providers.

7.9.2. 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. These changes would include, but would not be limited to, changes in expanded services, payments, or eligibility of a new population.

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

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

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

7.9.6. The CCN shall notify the 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 when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR 438.207(c)]. The notification shall include:

7.9.6.1. Information about how the provider network change will affect the delivery of covered services, and

7.9.6.2. The CCN's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.

7.9.7. CCN's 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.

7.10. Coordination with Other Service Providers

The CCN shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).

7.11. Patient-Centered Medical Home (PCMH)

7.11.1. Patient-Centered Medical Home (PCMH) is a system 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, mental health programs, and home health agencies. The CCN shall promote and facilitate the capacity of primary care practices to function as patient-centered medical homes by using systematic, patient-centered and coordinated care management processes; and to receive National Committee on Quality Assurance (NCQA) Physician Practice Connections®-Patient-Centered Medical Home (PPC®-PCMH) recognition or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Primary Care Home (PCH) accreditation.

7.11.2. 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:

7.11.2.1. 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;

7.11.2.2. 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);

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

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

7.11.3. 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:

7.11.3.1. By the end of the first year of operations under the Contract:

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

7.11.3.2. 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 a

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

7.11.3.3. 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 a

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

7.11.4. 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. .

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

7.11.6. 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.

7.11.7. 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.

7.12. Subcontract Requirements

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

7.12.2. In order to ensure that members have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to providers or services, the CCN shall not have a contract arrangement with any service provider in which the provider represents or agrees that it will not contract with another CCN or in which the CCN represents or agrees that it will not contract with another provider. The CCN shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider.

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

7.12.3.1. The CCN shall follow the state's credentialing and re-credentialing policy.

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

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

7.12.5. As required by 42 CFR §438.6(1), §438.230(a) and § 438.230(b)(1),(2),(3) the CCN shall be responsible to oversee all subcontractors' performance and shall be held accountable for any function and responsibility that it delegates to any subcontractor, including, but not limited to:

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

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

7.12.5.3. The CCN must evaluate the prospective subcontractor's ability to perform the activities to be delegated;

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

7.12.5.5. 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;

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

7.12.5.7. The CCN shall specifically deny payments to subcontractors for Provider Preventable Conditions

7.12.6. 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.

7.12.7. Notification of amendments or changes to any provider subcontract which, in accordance with §7.6 of this RFP, materially affects this Contract, shall be provided to DHH prior to the execution of the amendment in accordance with §23.1 of this RFP.

7.12.8. The CCN shall not execute provider subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to

§§ 1128 (42 U.S.C. 1320a-7) (2001, as amended) or 1156 (42 U.S.C. 1320 c-5) (2001, as amended) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. The 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.

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

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

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

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

7.13. Provider-Member Communication Anti-Gag Clause

7.13.1. 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:

7.13.1.1. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

7.13.1.2. Any information the member needs in order to decide among relevant treatment options;

7.13.1.3. The risks, benefits and consequences of treatment or non-treatment; and

7.13.1.4. 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.

7.13.2. 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.

7.13.3. 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.

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8.0 UTILIZATION MANAGEMENT

8.1. General Requirements

8.1.1. The CCN shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization. The CCN shall submit UM policies and procedures to DHH for written approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions.

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

8.1.2.1. Are adopted in consultation with a contracting health care professionals;

8.1.2.2. Are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

8.1.2.3. Are consider the needs of the members;

8.1.2.4. Are reviewed annually and updated periodically as appropriate;

8.1.3. The policies and procedures shall included, but not be limited to:

8.1.3.1. The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;

8.1.3.2. The data sources and clinical review criteria used in decision making;

8.1.3.3. The appropriateness of clinical review shall be fully documented;

8.1.3.4. The process for conducting informal reconsiderations for adverse determinations;

8.1.3.5. Mechanisms to ensure consistent application of review criteria and compatible decisions;

8.1.3.6. Data collection processes and analytical methods used in assessing utilization of health care services; and

8.1.3.7. Provisions for assuring confidentiality of clinical and proprietary information.

8.1.4. The CCN shall coordinate the development of clinical practice guidelines with other DHH CCN's to avoid providers receiving conflicting practice guidelines from different CCN's.

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

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

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

8.1.7.1. The vendor must be identified if the criteria was purchased;

8.1.7.2. 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;

8.1.7.3. The guideline source must be identified if the criteria are based on national best practice guidelines; and

8.1.7.4. The individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the CCN medical director or other qualified and trained professionals.

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

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

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

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

8.1.12. The CCN shall use DHH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations. The CCN shall specify what constitutes "medically necessary services" in accordance with 42 CFR §422.210 (a)(4).

8.1.13. The CCN shall address the extent to which it is responsible for covering services related to the following:

8.1.13.1. The prevention, diagnosis, and treatment of health impairments.

8.1.13.2. The ability to achieve age-appropriate growth and development.

8.1.13.3. The ability to attain, maintain, or regain functional capacity.

8.1.14. The CCN must identify the qualification of staff who will determine medical necessity.

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

8.1.16. 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.

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

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

8.1.19. 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.

8.1.20. 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 in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.

8.1.21. 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).

8.1.22. In accordance with 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:

8.1.22.1. Identification of the enrollee;

8.1.22.2. The name of the enrollee's physician;

8.1.22.3. Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;

8.1.22.4. The plan of care required under 42 CFR §456.80 and §456.180;

8.1.22.5. Initial and subsequent continued stay review dates described under 42 CFR §§456.128, 456.133; 456.233 and 456.234;

8.1.22.6. Date of operating room reservation, if applicable;

8.1.22.7. Justification of emergency admission, if applicable;

8.2. Utilization Management Committee

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

8.2.2. The UM Committee shall provide utilization review and monitoring of UM activities of both the 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:

8.2.2.1. Monitoring providers' requests for rendering healthcare services to its members;

8.2.2.2. Monitoring the medical appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling;

8.2.2.3. Reviewing the effectiveness of the utilization review process and making changes to the process as needed;

8.2.2.4. Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;

8.2.2.5. Monitoring consistent application of "medical necessity" criteria;

8.2.2.6. Application of clinical practice guidelines;

8.2.2.7. Monitoring over- and under-utilization;

8.2.2.8. Review of outliers, and

8.2.2.9. 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.

- **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 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.

8.2.3. 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.

8.2.4. 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.

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

8.3. Utilization Management Reports

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

8.4. Service Authorization

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

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

8.4.2.1. Written policies and procedures for processing requests for initial and continuing authorizations of services, where a 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;

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

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

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

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

8.4.2.6. The 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.

8.5. Timing of Service Authorization Decisions

8.5.1.1. Standard Service Authorization

8.5.1.1.1. The CCN shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service unless an extension is requested.

8.5.1.1.2. An extension may be granted for an **additional** fourteen (14) calendar days if the member or the provider or authorized representative requests an extension **or** if the CCN justifies to DHH a need for additional information and the extension is in the member's best interest. In no instance shall any determination of standard service authorization be made later than (28) calendar days from receipt of the request.

8.5.1.1.3. The CCN shall make concurrent review determinations within one (1) business day of obtaining the appropriate medical information that may be required.

8.5.1.2. Expedited Service Authorization

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

8.5.1.3. Post Authorization

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

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

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

8.5.1.4. Timing of Notice

8.5.1.4.1. Notice of Action

8.5.1.4.1.1. 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 health care professional or facility or both, and the member receiving the service within one (1) business day of the service authorization approval.

8.5.1.4.2. Adverse

- 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 § 13 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 § 12 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.

8.5.1.5. Informal Reconsideration

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

- In a case involving an initial determination or a concurrent review determination, the CCN should provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination (§438.402(b)(ii).

- The informal reconsideration should occur within one (1) working day of the receipt of the request and should be conducted between the provider rendering the service and the CCN's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) working day.

8.5.1.5.2. The Informal Reconsideration will in no way extend the 30 day required timeframe for a Notice of Appeal Resolution.

8.5.1.6. Exceptions to Requirements

- 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.

- The CCN shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.

- The CCN shall not require service authorization or referral for EPSDT screening services.

- 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.

- The CCN shall not require 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.

- The CCN shall not require a PCP referral for in-network eye care and vision services.

- The CCN may request to be notified by the provider, but shall not deny claims 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.

8.6. Medical History Information

8.6.1. 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.

8.6.2. 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.

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

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

8.7. PCP Utilization and Quality Profiling

8.7.1. The CCN shall profile its PCPs and analyze utilization data to identify PCP Utilization and/or quality of care issues.

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

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

8.7.3.1. Utilization of out-of-network providers – The CCN shall maintain a procedure to identify and evaluate member out-of-network provider referral utilization by its PCP panel;

8.7.3.2. Specialist referrals – The CCN shall maintain a procedure to identify and evaluate member specialty provider referral utilization by its PCP panel;

8.7.3.3. Emergency department utilization – The CCN shall maintain a procedure to identify and evaluate member emergency department referral utilization by its PCP panel;

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

8.7.3.5. Individual PCP clinical quality performance measures as indicated in Appendix J.

8.8. 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.

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9.0 PROVIDER PAYMENTS

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

9.1. Minimum Reimbursement to In-Network Providers

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

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

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

> Louisiana Department of Health & Hospitals
> Medicaid Coordinated Care Networks Program
> 628 North 4th Street
> Baton Rouge, LA 70802

9.2. FQHC/RHC Contracting and Reimbursement

9.2.1. A CCN must offer to contract with all FQHCs and RHCs in it service area. If an agreement cannot be reached between the CCN and FQHC/RHC, the CCN shall inform DHH.

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

9.2.3. The CCN shall reimburse an FQHC/RHC the Prospective Payment System (PPS) rate in effect on the date of service for each encounter.

9.2.4. If a CCN is unable to contract with an FQHC or RHC within the geographic service area and PCP time and distance travel standards, (Section § 7.3.2.1) the CCN is not required to reimburse that FQHC or RHC for out-of-network services if FQHC or RHC services within Time and Distance to Primary Care Standards are available in that area unless:

9.2.4.1. The medically necessary services are required to treat an emergency medical condition; or

9.2.4.2. FQHC/RHC services are not available through CCNs (CCN-P or CCN-S) in the GSA within DHH's established time and distance travel standards.

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

9.2.6. While CCNs are not, in general, financially responsible for specialty behavioral health services, CCNs are responsible for all behavioral health services provided at FQHCs/RHCs.

9.2.7. The CCN shall inform members of these rights in their member handbooks.

9.3. Reimbursement to Out-of-Network Providers

9.3.1. The CCN shall make prompt payment for covered emergency and post-stabilization services that are furnished by providers that have no arrangements with the CCN for the provision of such services. The CCN shall reimburse the provider one hundred percent (100%) of the Medicaid rate for emergency services. In compliance with Section 6085 of the Deficit Reduction Act (DRA) of 2005, reimbursement by the CCN to out-of-network providers for the provision of emergency services shall be no more than what would be paid under Medicaid FFS by DHH.

For services that do not meet the definition of emergency services, the CCN is not required to reimburse more than 90% of the published Medicaid FFS rate in effect on the date of service to out-of-network providers to whom they have made at least three (3) documented attempts (see Glossary) to include the provider in their network (except as noted in Section § 9.2).

9.4. Effective Date of Payment for New Members

The CCN is not responsible for payment for core benefits and services prior to the effective date of a member's CCN enrollment.

9.4.1. For newborns, the effective date of enrollment is the date of birth and payment will be made to the CCN for the full month.

9.4.2. For new CCN enrollees other than newborns, the effective date of enrollment in the CCN Program is the first day of the following month.

9.5. Claims Processing Requirements

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

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

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

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

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

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

9.5.4. The CCN shall encourage that its providers, as an alternative to the filing of paper-based claims, submit and receive claims information through electronic data interchange (EDI), i.e. electronic claims. Electronic claims must be processed in adherence to information exchange and data management requirements specified in Section § 17 if this RFP. As part of this Electronic Claims Management (ECM) function, the CCN shall also provide on-line and phone-based capabilities to obtain claims processing status information.

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

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

9.5.7. Not later than the fifteenth (15th) Business Day after the receipt of a Provider Claim that does not meet Clean Claim requirements, the CCN shall suspend the Claim and request in writing (notification via e-mail, the CCN Web site/Provider Portal or an interim Explanation of Benefits satisfies this requirement) all outstanding information such that the Claim can be deemed clean. After receipt of the requested information from the Provider, the CCN must process the Claim within fifteen (15) business days of the date of receipt (the date the CCN receives the claim as indicated by the date stamp on the claim).

9.5.8. Claims suspended for additional information must be closed (paid or denied) by the thirtieth (30th) Calendar Day following the date the Claim is suspended if all requested information is not received prior to the expiration of the 30-day period. The CCN shall send Providers written notice (notification via e-mail, the CCN Web Site/Provider Portal or an Explanation of Benefits satisfies this requirement) for each Claim that is denied, including the reason(s) for the denial and the date CCN received the Provider to adjudicate the Claim.

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

9.5.10. The CCN shall process all appealed Claims to a paid or denied status within (30) Business Days of receipt of the Appealed Claim.

9.5.11. The CCN shall finalize all Claims, including appealed Claims, within twenty-four (24) months of the date of service.

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

9.5.13. The CCN shall deny payment for Provider Preventable Conditions as defined by DHH.

9.5.14. The CCN shall inform all network Providers about the information required to submit a Clean Claim at least thirty (30) Calendar Days prior to the Operational Start Date. The CCN shall make available to network Providers claims coding and processing guidelines for the applicable Provider type. The CCN shall notify Providers ninety (90) Calendar Days before implementing changes to Claims coding and processing guidelines.

9.5.15. In addition to the specific Web site requirements outlined above, the CCNs Web site shall be functionally equivalent to the Web site maintained by DHHs FI.

9.5.16. For the purposes of CCN reporting on payments to providers, an adjustment to a paid Claim shall not be counted as a Claim and Electronic Claims shall be treated as identical to paper-based Claims.

9.6. Inappropriate Payment Denials

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

9.7. Payment for Emergency Services and Post-stabilization Services

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

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

9.7.1.2. The CCN may not limit what constitutes an emergency medical condition on the basis of diagnoses or symptoms or refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's PCP or CCN of the member's screening and treatment within ten (10) calendar days of presentation for emergency services.

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

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

9.7.1.5. The CCN may not make payment for emergency services contingent upon the member providing the CCN with notification either before or after receiving emergency services. The CCN may, however, enter into contracts with providers or facilities that require, as a condition of payment, the provider or facility to provide notification to the CCN after members are present at the emergency room, assuming adequate provision is given for such notification.

9.7.1.6. The CCN shall be financially responsible for emergency medical transportation and shall not retroactively deny a claim for emergency transportation to an emergency provider because the condition, which appeared to be an Emergency Medical Condition under the prudent layperson standard, was subsequently determined to be non-emergency in nature.

9.7.2. The CCN is financially responsible (consistent with 42 CFR §422.214) for post-stabilization care services, as specified in 42 CFR §438.114(e) and 42 CFR §422.113(c)(2)(i), (ii) and (iii), obtained within or outside the CCN that are:

9.7.2.1. Pre-approved by a network provider or other CCN representative; or

9.7.2.2. Not preapproved by a network provider or other CCN representative, but:

- Administered to maintain the member's stabilized condition within one (1) hour of a request to the CCN for pre-approval of further post-stabilization care services;

- Administered to maintain, improve or resolve the member's stabilized condition if the CCN:

- Does not respond to a request for pre-approval within one (1) hour;
- Cannot be contacted; or
- CCN's representative and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the CCN must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of 422.133(c)(3) is met.

- Are for post-stabilization hospital-to-hospital ambulance transportation of members with a behavioral health condition, including hospital to behavioral health specialty hospital.

9.7.3. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the CCN as responsible for coverage and payment as per 42 CFR §438.114(d). The CCN's financial responsibility ends for post stabilization care services it has not pre-approved when:

9.7.3.1. A network physician with privileges at the treating hospital assumes responsibility for the member's care;

9.7.3.2. A network physician assumes responsibility for the member's care through transfer;

9.7.3.3. A representative of the CCN and the treating physician reach an agreement concerning the member's care; or

9.7.3.4. The member is discharged.

9.7.4. Expenditures for the medical services as previously described have been factored into the capitation rate described in §5.0 of this RFP and the CCN will not receive any additional payments.

9.8. Physician Incentive Plans

9.8.1. In accordance with 42 CFR §422.208 and §422.210, the CCN may operate a Physician Incentive Plan (PIP), but specific payment cannot be made directly or indirectly under a Physician Incentive Plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

The CCN's incentive plans for its network providers/subcontractors shall be in compliance with 42 CFR §§§438.6(h), 422.208 and 422.210. (See Appendix Q, **Requirements for CCN-P Physician Incentive Plans**).

9.8.2. The CCN shall submit any information regarding incentives as may be required by DHH (see §**9.8.2.1**). The CCN shall receive approval from DHH prior to implementation of the PIP.

9.8.2.1. The CCN shall receive prior DHH approval of the Physician Incentive Plan and shall submit to DHH any contract templates that involve a PIP for review as a material modification. The CCN shall disclose 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 conduct periodic surveys of current and former enrollees where substantial financial risk exists (in accordance with 42 CFR §422.208(h). A summary of the results must be provided to any beneficiary who requests it (42 CFR §422.210(b)).

9.8.2.2. 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).

9.9. Supplemental Provider Payments

The CCN is not responsible for reimbursement of graduate medical education (GME) payments, disproportionate share hospital (DSH) payments, or upper payment limit (UPL) payments to providers.

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10.0 PROVIDER SERVICES

10.1. Provider Relations

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

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

10.1.2. Assure each CCN provider is provided all rights outlined the **Provider's Bill of Rights** (see Appendix R);

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

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

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

10.2. Provider Toll-free Telephone Line

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

10.2.2. The provider access component of the toll-free telephone line must be staffed between the hours of 7am -7pm Central Time Monday through Friday to respond to provider questions in all areas, including provider complaints and regarding provider responsibilities. The provider access component must be staffed on a 24/7 basis for prior authorization requests.

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

10.2.4. After normal business hours, the provider service component of the toll-free telephone line must include the capability of providing information regarding normal business hours and instructions to verify enrollment for any 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.

10.3. Provider Website

10.3.1. 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.

10.3.2. 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:

10.3.2.1. CCN provider manual;

10.3.2.2. CCN-relevant DHH bulletins;

10.3.2.3. Limitations on provider marketing;

10.3.2.4. Information on upcoming provider trainings;

10.3.2.5. A copy of the provider training manual;

10.3.2.6. Information on the provider grievance system;

10.3.2.7. Information on obtaining prior authorization and referrals; and

10.3.2.8. Information on how to contact the CCN Provider Relations.

10.3.3. 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 CCN signs the Contract.

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

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

10.3.6. 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.

10.4. Provider Handbook

10.4.1. The CCN shall develop and issue a provider handbook within thirty (30) days of the date the CCN signs the Contract with DHH. The CCN may choose not to distribute the provider handbook via surface mail, provided it submits a written notification to all providers that explains how to obtain the provider handbook from the 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 covered 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:

10.4.1.1. Description of the CCN;

10.4.1.2. Description and requirements of Patient-Centered Medical Home recognition;

10.4.1.3. Core benefits and services the CCN must provide;

10.4.1.4. Emergency service responsibilities;

10.4.1.5. 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;

10.4.1.6. 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;

10.4.1.7. Medical necessity standards as defined by DHH and practice guidelines;

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

10.4.1.9. PCP responsibilities;

10.4.1.10. Other provider responsibilities under the subcontract with the CCN;

10.4.1.11. Prior authorization and referral procedures;

10.4.1.12. Medical records standards;

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

10.4.1.14. CCN prompt pay requirements (see Section § 9);

10.4.1.15. Notice that provider complaints regarding claims payment shall be sent to the CCN;

10.4.1.16. The CCN's chronic care management program;

10.4.1.17. Quality performance requirements; and

10.4.1.18. Provider rights and responsibilities.

10.4.2. The CCN shall disseminate bulletins as needed to incorporate any changes to the provider handbook.

10.4.3. The shall make available to DHH for approval a provider handbook specific to the Louisiana CCN Program, no later than thirty (30) days prior from the date the CCN signs the Contract with DHH.

10.5. Provider Education and Training

10.5.1. The CCN shall provide training to all providers and their staff regarding the requirements of the Contract, including limitations on provider marketing, and identification of special needs of members. The 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.

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

10.6. Provider Complaint System

10.6.1. The 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:

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

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

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

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

10.6.2. 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. The policies and procedures shall include, at a minimum:

10.6.2.1. Allowing providers thirty (30) days to file a written complaint and a description of how providers file complaint with the CCN and the resolution time;

10.6.2.2. A description of how and under what circumstances providers are advised that they may file a complaint with the 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;

10.6.2.3. 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;

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

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

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

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

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

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

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

10.6.2.11. Allowing providers that have exhausted the CCNs internal complaint process related to a denied or underpaid claims or a group of claims bundled, the option to request binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If the CCN and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this section shall be binding on all parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) days of being selected, unless the CCN and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

10.6.3. 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.

10.6.3.1. 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.

10.6.3.2. The CCN provider shall file all appeals for the denial, reduction or suspension of medically necessary services through the state fair hearing process. See §13 of the RFP for notice of grievance and state fair hearing procedures.

10.6.3.3. 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.

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11.0 ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

DHH contracts 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 be 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.

11.1. Enrollment Counseling

11.1.1. 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.

11.1.2. The Enrollment Broker's responsibilities subsequent to eligibility determination will include, but will not be necessarily be limited to, the following:

11.1.2.1. 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, 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.

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

11.1.2.3. 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 availability, any enhanced benefits).

11.1.2.4. Identifying any barriers to access to care for the CCN members such as:

11.1.2.4.1. Necessity for multi-lingual interpreter services, and

11.1.2.4.2. Special assistance needed for members with visual and hearing impairment and members with physical or mental disabilities.

11.1.3. 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 Part §438.104, in an objective, non-biased fashion that neither favors nor discriminates against any CCN or health care provider.

11.1.4. The importance of early selection of a CCN will be stressed, especially if the Medicaid potential enrollee indicates priority health needs.

11.1.5. 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.

11.1.6. 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.

11.1.7. The Enrollment Broker shall be responsible for distributing all enrollment materials to all eligible Medicaid enrollees by mail and/or other suitable means.

11.2. Voluntary Selection of a CCN

11.2.1. 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.

11.2.2. 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.

11.2.3. 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.

11.3. Automatic Assignment

11.3.1. 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.

11.3.2. The Enrollment Broker's automatic assignment methodology shall be based on the following hierarchy:

11.3.2.1. The member's previous CCN;

11.3.2.2. 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.

11.3.2.3. Inclusion in the CCN provider network of a family member's current or historic provider 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.

11.3.2.4. 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.

11.3.2.5. Beginning in October 2014, the CCN's quality measures will be factored into the algorithm for automatic assignment.

11.3.3. Neither the CCN-P Model nor the CCN-S Model will be given preference in making auto assignments.

11.3.4. If an entity is operating both a Prepaid and a Shared Savings Model CCN within a GSA, it will be treated as one entity for any round robin auto assignment purposes, with assignment made equally between the two.

11.4. Automatic Re-Assignment 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.

11.5. 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.

11.6. CCN Lock-In Period

11.6.1. 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.

11.6.2. Following their initial enrollment into a CCN, members have ninety (90) days from the postmark date of the Notice of Enrollment in which they may change CCNs for any reason. After the initial ninety (90) day period, Medicaid enrollees/members shall be locked into a CCN for twelve (12) additional months from the effective date of enrollment or until the next annual open enrollment period, unless disenrolled for cause.

11.7. Voluntary Enrollees

11.7.1. Voluntary potential enrollees will be given a thirty (30) day choice period to choose a CCN or opt out of the CCN program.

11.7.2. 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.

11.7.3. 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.

11.8. Open Enrollment

11.8.1. 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.

11.8.2. 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 individual 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.

11.8.3. 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.

11.9. Suspension of and/or Limits on Enrollments

11.9.1. 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.

11.9.2. Consistent with reporting requirements in Section §18.0 of this RFP, the CCN shall submit a quarterly update of the maximum members in each GSA. The CCN shall track slot availability and notify DHH's Enrollment Broker when filled slots are within 90% of capacity. The CCN is responsible for maintaining a record of total PCP linkages of Medicaid members and provide this information quarterly to DHH.

11.9.3. DHH will notify the CCN when the CCN's enrollment levels reach 95% of capacity and will not automatically assign Medicaid eligibles.

11.9.4. 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.

11.10. CCN Enrollment Procedures

11.10.1. Acceptance of All Eligibles

11.10.1.1. 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.

11.10.1.2. 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.

11.10.1.3. 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.

11.10.2. Effective Date of Enrollment

CCN enrollment, whether by member choice or automatic assignment, for members assigned on or before the third (3rd) to last working day of a given month will be effective at 12:01AM on the first (1st) calendar day of the month

following assignment. CCN enrollment for members assigned after the third (3rd) to last working day in a given month, will be effective at 12:01AM on the first (1st) calendar day of the second (2nd) month following assignment.

11.10.3. 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.

11.10.4. Newborn Enrollment

11.10.4.1. 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.

11.10.4.2. The CCN shall be responsible for assuring that hospital subcontractors report the births of newborns within twenty-four (24) hours of birth for enrolled members using DHH's web-based **Request for Newborn Manual** system. (See Appendix S). 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.

11.10.4.3. The CCN shall require its hospital providers to register all births through LEERS (Louisiana Electronic Event Registration System) administered by DHH/Vital Records Registry.

11.10.4.4. LEERS information and training materials at the following url:

http://www.dhh.louisiana.gov/offices/page.asp?id=252&detail=9535

11.10.5. Assignment of Primary Care Providers

11.10.5.1. As part of the financial Medicaid application process, applicants may be given the option to indicate their preferred choice of CCN and PCP.

11.10.5.2. 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.

11.10.5.3. The Enrollment Broker shall encourage the continuation of any existing satisfactory provider/patient relationship with their current PCP who is in a CCN.

11.10.5.4. The name of PCP requested by a new enrollee will be included in the Member File from the Enrollment Broker to CCN.

11.10.5.5. The CCN shall confirm the PCP selection information in a written notice to the member.

11.10.5.6. If no PCP is selected on the Member File received from the Enrollment Broker, the CCN shall:

11.10.5.7. Contact the member, as part of the welcome process, 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;

11.10.5.8. 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.;

11.10.5.9. 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.

11.10.5.10. The CCN shall have written policies and procedures for handling the assignment of its members to a PCP. The CCN is responsible for linking all assigned CCN members to a PCP.

11.11. PCP Auto-Assignments

11.11.1. 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:

11.11.1.1. Does not make a PCP selection after a voluntary selection of a CCN; or

11.11.1.2. Selects a PCP within the CCN that has reached their maximum physician/patient ratio; or

11.11.1.3. Selects a PCP within the CCN that has restrictions/limitations (e.g. pediatric only practice).

11.11.2. 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 who a family member has a historical provider relationship.

11.11.3. 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.

11.11.4. The final CCN and PCP automatic assignment methodology must be provided thirty (30) days from the date the CCN signs the contract .with DHH Approval must be obtained from the Department prior to implementation. This methodology must be made available via the CCN's website, Provider Handbook, and Member Handbook..

11.11.5. 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 on a quarterly basis.

11.11.6. 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.

11.11.7. 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 months (12) months beginning from the original date the member was assigned to the CCN.

11.11.8. If a member requests to change his or her PCP with cause, at any time during the enrollment period, the CCN must agree to grant the request.

11.11.9. 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 termination of PCP notice to members and provide information on options for selecting a new PCP.

11.11.10. 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.

11.11.11. The CCN shall notify the Enrollment Broker by close of business the next business day of a PCP's termination.

11.12. 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.

11.12.1. Member Initiated Disenrollment

A member may request disenrollment from a CCN as follows:

11.12.1.1. 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;
- The contract between the CCN and DHH is terminated;
- 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; and
- Any other reason deemed to be valid by DHH and/or its agent.

11.12.1.2. 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; and
- 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.
- If DHH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a) (3).

11.12.1.3. The member (or his/ her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.

11.12.1.4. If the member's request for disenrollment is denied by the Enrollment Broker, the member can appeal directly to the State Fair Hearing process.

11.12.2. CCN Initiated Disenrollment

11.12.2.1. The CCN shall not request disenrollment because of 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 CCN members, 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. (42 CFR, Part 438.52).

11.12.2.2. The CCN shall not request disenrollment for reasons other than those stated in this RFP. (See Appendix U –**Guidelines for Involuntary Member Disenrollment**). In accordance with 42 CFR 438.56(b)(3), DHH will ensure that CCN is not requesting disenrollment for other reasons by reviewing 1) the mandatory CCN Disenrollment Request Forms submitted to the Enrollment Broker and 2) Quarterly Disenrollment Reports submitted by the CCN to DHH.

11.12.2.3. The following are allowable reasons for which the CCN may request involuntary disenrollment of a member:

- The member misuses or loans the member's CCN-issued ID card to another person to obtain services. In such case the CCN shall report the event to the Medicaid Program Integrity Section;

- 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.

11.12.2.4. 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

11.12.2.5. 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.

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11.12.2.6. The CCN shall submit disenrollment requests to the Enrollment Broker which should include, at a minimum the member's name, ID number, detailed reasons for requesting the disenrollment, and a description of the measures taken to correct member behavior prior to requesting disenrollment, utilizing the **CCN Initiated Request for Member Disenrollment** form (See Appendix T).

11.12.2.7. 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.

11.12.2.8. 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 dispute resolution process by the CCN.

11.12.2.9. 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.

11.12.2.10. 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.

11.12.3. DHH Initiated Disenrollment

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

11.12.3.1. Loss of Medicaid eligibility or loss of CCN enrollment eligibility;

11.12.3.2. Death of a member;

11.12.3.3. Member's intentional submission of fraudulent information;

11.12.3.4. Member becomes an inmate in a public institution;

11.12.3.5. Member moves out-of-state;

11.12.3.6. Member becomes Medicare eligible;

11.12.3.7. Member is placed in a long term care facility (nursing facility or intermediate care facility for persons with developmental disabilities);

11.12.3.8. Member becomes a participant in a home and community-based services waiver;

11.12.3.9. Member elects to receive hospice services; and

11.12.3.10. 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.

11.12.4. Disenrollment Effective Date

11.12.4.1. 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.

11.12.4.2. 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.

11.12.4.3. DHH, the CCN, and the Enrollment Broker shall reconcile enrollment/disenrollment issues at the end of each month utilizing an agreed upon procedure.

11.12.5. Transition of Enrollment

11.12.5.1. The CCN must provide active assistance to members when transitioning to another CCN or back to the Medicaid Fee-for-Service Program.

11.12.5.2. 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.

11.12.5.3. The transition period shall not exceed thirty (30) calendar days from the effective date of the member's enrollment in the receiving CCN.

11.12.5.4. During this transition period, the receiving CCN shall be responsible for, but not limited to, 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.

11.12.5.5. 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.

11.12.5.6. 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.

- 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.

- 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.

11.13. Enrollment and Disenrollment Updates

11.13.1. 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 their CCN for the following month. The CCN will receive this notification through the ASC X12N 834 Benefit Enrollment and Maintenance electronic transaction.

11.13.2. 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.

11.14. Daily Updates

The Enrollment Broker shall make available to the CCN daily via electronic media, (ASC X12N 834 Benefit Enrollment and Maintenance transaction) updates on members newly enrolled into the CCN in the format specified in the ***CCN-P 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 their providers. Policies and procedures shall be available for review at the pre-implementation Readiness Review.

11.15. Weekly Reconciliation

11.15.1. 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..

11.15.2. Payment

The CCN will receive monthly electronic file (ASC X12N 820 Transaction) from the Medicaid Fiscal Intermediary (FI) listing all members for whom the CCN received a capitation payment and the amount received. The CCN is responsible for reconciling this listing against its internal records. 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 §20.0 of this RFP until requirements are met.

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12.0 MARKETING AND MEMBER EDUCATION

12.1. General Guidelines

12.1.1. Marketing, for purposes of this RFP, is defined in 42 CFR §438.104 (a) as any communication from 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.

12.1.2. 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.

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

12.1.4. Marketing materials generally include, but are not limited to, the concepts of advertising, public service announcements, printed publications, broadcasts and electronic messages designed to increase awareness and interest in the 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.

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

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

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

12.1.8. All marketing and member education materials and activities shall comply with the requirements in 42 CFR § 438.10 and the DHH requirements set forth in this RFP.

12.1.9. 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.

12.1.10. 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) and 42 CFR §438.104.

12.1.11. 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.

12.1.12. 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) and 42 CFR § 438.104.

12.1.13. The CCN shall comply with the Office of Minority Health, Department of Health and Human Services' "Cultural and Linguistically Appropriate Services Guidelines" at the following url: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 and participate in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees.

12.2. Marketing and Member Education Plan

12.2.1. The 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.

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

12.2.3. The CCN should develop a separate marketing and member education plan for each GSA for which it has received an award and entered into a Contract. 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:

12.2.3.1. Stated marketing and member education goals and strategies;

12.2.3.2. A marketing and member education calendar, which begins with the date of the signed contract, between DHH and 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.);

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

12.2.3.4. The CCN's plans for new member outreach, including welcome packets and welcome call;

12.2.3.5. 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 ;

12.2.3.6. How the CCN 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);

12.2.3.7. A list of all subcontractors engaged in marketing or member education activities for the CCN;

12.2.3.8. A copy of the CCN training curriculum for marketing representatives (both internal and subcontractor);

12.2.3.9. 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;

12.2.3.10. Copies of all marketing and member education materials (print and multimedia) the CCN or any of its subcontractor's plans 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 W);

12.2.3.11. 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;

12.2.3.12. 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 X);

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

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

12.2.3.15. 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).

12.2.3.16. 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.

12.3. Prohibited Marketing Activities

The CCN and its subcontractors are prohibited from in engaging in the following activities:

12.3.1. Marketing directly 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);

12.3.2. Asserting that the CCN is endorsed by CMS, the federal or state government or similar entity;

12.3.3. 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;

12.3.4. Portraying competitors or potential competitors in a negative manner;

12.3.5. Attaching a Medicaid application and/or enrollment form to marketing materials;

12.3.6. Assisting with enrollment or improperly influencing CCN selection;

12.3.7. Inducing or accepting a member's enrollment or disenrollment;

12.3.8. 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;

12.3.9. 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;

12.3.10. Comparing their CCN to another organization/CCN by name;

12.3.11. Sponsoring or attending any marketing or community health activities or events without notifying DHH within the timeframes specified in this RFP;

12.3.12. 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;

12.3.13. 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 enrollees or the general public;

12.3.14. 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;

12.3.15. Marketing or distributing marketing materials, including member handbooks, and soliciting members in any other manner, inside, at the entrance or within 100 feet 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;

12.3.16. Conducting marketing or distributing marketing materials in hospital emergency rooms, including the emergency room waiting areas, patient rooms or treatment areas;

12.3.17. 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;

12.3.18. Purchasing or otherwise acquiring or using mailing lists of Medicaid eligibles from third party vendors, including providers and state offices;

12.3.19. Using raffle tickets or event attendance or sign-in sheets to develop mailing lists of prospective enrollees;

12.3.20. Charging members for goods or services distributed at events;

12.3.21. Charging members a fee for accessing the CCN Web site;

12.3.22. Influencing enrollment in conjunction with the sale or offering of any private insurance;

12.3.23. 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;

12.3.24. Using terms that would influence, mislead or cause potential members to contact the CCN, rather than the DHH-designated Enrollment Broker, for enrollment;

12.3.25. Referencing the commercial component of the CCN in any of its Medicaid CCN enrollee marketing materials, if applicable;

12.3.26. Using terms in marketing materials such as “choose,” “pick,” “join,” etc. unless the marketing materials include the Enrollment Broker’s contact information;

12.4. Allowable Marketing Activities

The CCN and its subcontractors shall be permitted to perform the following activities:

12.4.1. 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;

12.4.2. 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;

12.4.3. 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;

12.4.4. Provide promotional giveaways that exceed the $15.00 value to current members only;

12.4.5. 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;

12.4.6. 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;

12.4.7. 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. The CCN must utilize the response plan outline in the marketing plan, approved by DHH, during these calls; and

12.4.8. Send plan-specific materials to potential members at the potential member’s request.

12.4.9. In any instance where a CCN allowable activity conflicts with a prohibited activity, the prohibited activity guidance shall be followed

12.5. Marketing and Member Education Materials Approval Process

12.5.1. 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.

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

12.5.2.1. 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.

12.5.3. 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).

12.5.4. Review Process for Materials

12.5.4.1. 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;

12.5.4.2. 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;

12.5.4.3. 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;

12.5.4.4. DHH reserves the right to require the CCN to discontinue or modify any marketing or member education materials after approval;

12.5.4.5. 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

12.5.4.6. 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.

12.6. Events and Activities Approval Process

12.6.1. 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.

12.6.2. All proposed events and activities must be submitted to DHH using **Event Submission Form**. (See Appendix X)

12.6.2.1. 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.

12.6.3. Review Process for Events and Activities

12.6.3.1. 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.

12.6.3.2. 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.

12.6.3.3. DHH reserves the right to require the CCN to discontinue or modify any marketing or member education events after approval.

12.6.3.4. 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.

12.6.3.5. 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.

12.6.3.6. Any revisions to approved events and activities must be resubmitted for approved by DHH prior to the event or activity.

12.7. CCN Provider Marketing Guidelines

12.7.1. 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.

12.7.2. The CCN may not require its providers to distribute CCN-prepared communications to their patients.

12.7.3. The CCN may not provide incentives or giveaways to providers to distribute them to CCN members or potential CCN members.

12.7.4. The CCN may not conduct member education in common areas of provider offices.

12.7.5. The CCN may not allow providers to solicit enrollment or disenrollment in a CCN, or distribute CCN-specific materials at a marketing activity.

12.7.6. The CCN shall instruct participating providers regarding the following communication requirements:

12.7.6.1. 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;

12.7.6.2. 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.

12.7.6.3. 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 contract.

12.7.6.4. 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.

12.7.6.5. CCN stickers indicating the provider participates with a particular CCN cannot be larger than 5" x 7" and not indicate anything more than "the health plan or CCN is accepted or welcomed here."

12.7.6.6. 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.

12.7.6.7. Upon termination of a contract 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.

12.8. CCN Marketing Representative Guidelines

12.8.1. 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.

12.8.2. 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.

12.8.3. 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.

12.8.4. Sign-on bonuses for marketing representatives are prohibited.

12.8.5. 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.

12.9. Written Materials 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.):

12.9.1. 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 6.9 grade level, as determined by any one of the indices below, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy:

:

- Flesch – Kincaid;
- Fry Readability Index;
- PROSE The Readability Analyst (software developed by Educational Activities, Inc.);

- Gunning FOG Index;
- McLaughlin SMOG Index; or
- Other computer generated readability indices accepted by DHH
-

12.9.2. All written materials must be clearly legible with a minimum font size of ten-point, preferably twelve-point, with the exception of Member ID cards, and unless otherwise approved by DHH.

12.9.3. DHH reserves the right to require evidence that a handbook has been tested against the 6.9 grade reading-level standard.

12.9.4. 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.

12.9.5. All written materials must be in accordance with the **DHH "Person First" Policy**, Appendix NN.

12.9.6. 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.

12.9.7. 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.

12.9.8. 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;

12.9.9. 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.

12.9.10. Alternative forms of communication must be provided upon request for persons with visual, hearing, speech, physical or developmental disabilities. These alternatives must be provided at no expense to the member.

12.9.11. 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.

12.9.12. All marketing activities should provide for equitable distribution of materials without bias toward or against any group.

12.9.13. Marketing materials must accurately reflect general information, which is applicable to the average potential enrollee of the CCN.

12.10. CCN Website Guidelines

12.10.1. 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.

12.10.2. The CCN must notify DHH when the website, which has been prior approved by DHH, is in place and when approved updates are made.

12.10.3. The CCN must remain -compliant with HIPAA privacy and security requirements when providing member eligibility or member identification information on the website.

12.10.4. 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.

12.10.5. Use of proprietary items that would require a specific browser is not allowed.

12.10.6. The CCN must provide the following information on its website, and such information shall be easy to find, navigate, and understand by all members:

12.10.6.1. The most recent version of the Member Handbook;

12.10.6.2. Telephone contact information, including a toll-free customer service number prominently displayed and a Telecommunications Device for the Deaf (TDD) number;

12.10.6.3. A searchable list of network providers with a designation of open versus closed panels, updated immediately upon changes to the network;

12.10.6.4. The link to the Enrollment Broker's website and toll free number for questions about enrollment;

12.10.6.5. The link to the Medicaid website (www.medicaid.dhh.louisiana.gov) and the toll free number (888-342-6207) for questions about Medicaid eligibility;

12.10.6.6. The capability for members to submit questions and comments to the CCN and receive responses;

12.10.6.7. A section for the CCN's providers that includes contact information, claims submittal information, prior authorization instructions, and a toll-free telephone number;

12.10.6.8. General customer service information; and

12.10.6.9. Information on how to file grievances and appeals.

12.11. Member Education – Required Materials and Services

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.

New Member Orientation

12.11.1.1. 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.

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

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

12.11.1.4. 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 PCP names (and include 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.

12.11.1.5. 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. These procedures shall adhere to the enrollment process and procedures outlined in this RFP and the Contract.

12.11.1.6. 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.

12.11.2. Communication with New Enrollees

12.11.2.1. DHH's Enrollment Broker shall send the CCN a daily file in the format specified in the **CCN Systems Companion Guide**. The file shall contain the names, addresses and phone numbers 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 an affirmative choice is 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 and initiate communication with new members via welcome packet mailings and welcome calls, as prescribed in this RFP.

- **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 phase-in implementation 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 each new member. When the name of the responsible party for the new member 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 described 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;

    - A Member Handbook;

    - The CCN Member ID Card; and

    - A Provider Directory (also must be available in searchable format on-line).

12.11.2.2. The CCN shall adhere to the requirements for the Member Handbook, ID card, and Provider Directory as specified in this RFP, its attachments, and in accordance with 42 CFR §438.10 (f)(6).

12.11.2.3. The CCN shall agree to make available the full scope of core benefits and services to which a member is entitled immediately upon his or her effective date of enrollment, which, with the exception of newborns, will always be the 1st day of a month.

- **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.

12.12. CCN Member Handbook

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

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

12.12.2.1. Table of contents;

12.12.2.2. 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;

12.12.2.3. Member's right to disenroll from CCN;

12.12.2.4. Member's right to change providers within the CCN;

12.12.2.5. Any restrictions on the member's freedom of choice among CCN providers;

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

12.12.2.7. 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;

12.12.2.8. Procedures for obtaining benefits, including prior authorization requirements;

12.12.2.9. Description on the purpose of the Medicaid card and the CCN card and why both are necessary and how to use them;

12.12.2.10. The extent to which, and how, members may obtain benefits, including family planning services and specialized behavioral health services from out-of-network providers;

12.12.2.11. 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.

12.12.2.12. The post-stabilization care services rules set forth in 42 CFR 422.113(c);

12.12.2.13. Policy on referrals for specialty care, including **specialized** behavioral health services and for other benefits not furnished by the member's PCP;

12.12.2.14. 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;

12.12.2.15. 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;

12.12.2.16. 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;

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

12.12.2.18. Grievance, appeal and fair hearing procedures that include the following:

- For State Fair Hearing:
  - The right to a hearing;
  - The method for obtaining a hearing; and
  - The rules that govern representation at the hearing.
- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The toll-free numbers that the member can use to file a grievance or an appeal by phone;
- The fact that, when requested by the member:
  - Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and

- The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

- In a State Fair Hearing, the Division of Administrative Law shall make the recommendation to the Secretary of the DHH who has final authority to determine whether services must be provided.

12.12.2.19. Advance Directives, set forth in 42 FR §438.6(i)(2) - A description of advance directives which shall include:

- The CCN policies related to advance directives;

- The member's rights under Louisiana state law, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change;

- Information that members can file complaints about the failure to comply with an advance directive with the Office of Health Standards, Louisiana's Survey and Certification agency) by calling 225 342 0138; and

- Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.

12.12.2.20. 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;

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

12.12.2.22. A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;

12.12.2.23. How to obtain emergency and non-emergency medical transportation;

12.12.2.24. Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;

12.12.2.25. 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;

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

12.12.2.27. 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;

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

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

12.12.2.30. Any additional text provided to the CCN by DHH or deemed essential by the CCN;

12.12.2.31. The date of the last revision;

12.12.2.32. 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 Z of this RFP)

12.13. Member Identification (ID) Cards

12.13.1. CCN members will receive two (2) member identification cards.

12.13.1.1. 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.

12.13.1.2. 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:

  o 24-hour Member Services and Filing Grievances

  o Provider Services and Prior Authorization and

  o Reporting Medicaid Fraud (1-800-488-2917)

12.13.2. The CCN shall issue the CCN Member ID card with the welcome packet. As part of the card 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.

12.13.3. The card will be issued without the PCP information if no PCP selection has been made on the date of the mailing.

12.13.4. 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 card.

12.13.5. 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.

12.13.6. 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.

12.13.7. 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.

12.14. Provider Directory for Members

12.14.1. The CCN shall develop and maintain a Provider Directory in four (4) formats:

12.14.1.1. A hard copy directory for members and upon request, potential members;

12.14.1.2. Web-based, searchable, online directory for members and the public; and

12.14.1.3. Electronic file of the directory for the Enrollment Broker.

12.14.1.4. Hard copy, abbreviated version for the Enrollment Broker.

12.14.2. 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.

12.14.3. 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 electronic version shall be updated prior to each submission to DHH's Fiscal Intermediary. While daily updates are preferred, the CCN shall at a minimum submit no less than weekly. The abbreviated hard copy version for the Enrollment Broker will be distributed to new Medicaid enrollees. Format for this version will be in a format specified by DHH.

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

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

12.14.4.2. Identification of primary care physicians, specialists, and hospitals PCP groups, clinic settings, FQHCs and RHCs in the service area;

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

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

12.14.5. 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.

12.15. Member Call Center

12.15.1. 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:

12.15.1.1. Explanation of CCN policies and procedures;

12.15.1.2. Prior authorizations;

12.15.1.3. Access information;

12.15.1.4. Information on PCPs or specialists;

12.15.1.5. Referrals to participating specialists;

12.15.1.6. Resolution of service and/or medical delivery problems; and

12.15.1.7. Member grievances.

12.15.2. 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.

12.15.3. The toll-free line shall have an automated system, available 24-hours a day, seven-days a week. This automated system must include the capability of providing callers with operating instructions on what to do in case of an emergency and the option to talk directly to a 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.

12.15.4. 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 are not sufficient to meet member needs as determined by DHH.

12.15.5. 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.

12.15.6. 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.

12.15.7. 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.

12.16. ACD System

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

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

12.16.1.2. Transfer calls to other telephone lines;

12.16.1.2.1. 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;

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

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

12.16.1.5. Measure the length of time callers are on hold;

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

12.16.1.6. Measure the average hours of use per day;

12.16.1.7. Assess the busiest times and days by number of calls;

12.16.1.8. Record calls to assess whether answered accurately;

12.16.1.8.1. 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;

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

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

12.16.2. Call Center Performance Standards

12.16.2.1. Answer ninety (90) percent of calls within thirty (30) seconds or an automatic call pickup system;

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

12.16.2.3. Maintain an average hold time of three (3) minutes or less;

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

12.16.2.4.1. The CCN must conduct ongoing quality assurance to ensure these standards are met.

12.16.2.4.2. 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.

12.16.2.5. 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

12.16.3. Members Rights

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

12.16.4. Member Responsibilities

12.16.4.1. 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.

12.16.4.2. 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 know 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.

12.17. Notice to Members of Provider Termination

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

12.17.2. 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.

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

12.18. Additional Member Educational Materials and Programs

The CCN shall prepare and distribute educational materials, including, but not limited to, the following:

12.18.1. 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;

12.18.2. 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;

12.18.3. Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;

12.18.4. Materials focused on health promotion programs available to the members;

12.18.5. Communications detailing how members can take personal responsibility for their health and self management;

12.18.6. Materials that promote the availability of health education classes for members;

12.18.7. Materials that provide education for members, with, or at risk for, a specific disability or illness;

12.18.8. 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;

12.18.9. Notification to its members their right to request and obtain the welcome packet at least once a year;

12.18.10. Notification to its members of any change that DHH defines as significant at least thirty (30) calendar days before the intended effective date; and

12.18.11. All materials distributed must comply with the relevant guidelines established by DHH for these materials and/or programs.

12.19. Oral and Written Interpretation Services

12.19.1. 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.

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

12.20. Marketing Reporting and Monitoring

12.20.1. Reporting to DHH

12.20.1.1. The CCN must provide a monthly report in a format prescribed by DHH (See Appendix BB, **Marketing Plan Monthly Report**) to demonstrate the progression of the marketing and member education plan. The monthly report must be provided by the 10th day of the following month and include a listing of all completed marketing activities and distributed marketing materials.

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

12.20.2. Reporting Alleged Marketing Violations

12.20.2.1. To ensure the fair and consistent investigation of alleged violations, DHH has outlined the following reporting guidelines:

12.20.2.2. Alleged marketing violations must be reported to DHH in writing utilizing the **Marketing Complaint Form**, (See Appendix Z).

12.20.2.3. 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 Section 20 of this RFP, for additional details).
- Notify the complainant after appropriate action has been taken.

12.20.3. Sanctions

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

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13.0 MEMBER GRIEVANCE AND APPEALS PROCEDURES

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

The CCN's grievance and appeals procedures and any changes thereto must be approved in writing by DHH prior to their implementation and must include at a minimum the requirements set forth in this RFP.

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

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

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

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

13.1. Applicable Definitions

13.1.1. Definition of Action

For purposes of this RFP an **action** is defined as:

- The denial or limited authorization of a requested service, including the type or level of service; or
- The reduction, suspension, or termination of a previously authorized service; or
- The denial, in whole or in part, of payment for a service; or
- The failure to provide services in a timely manner, as defined by **§7.3** an § **7.5** of this RFP; or

- The failure of the CCN to act within the timeframes provided in **§13.12.1** of this RFP.

13.1.2. Definition of Appeal

For purposes of this RFP an **appeal** is defined as a request for review of an action, as "action" is defined in Section §13.6.1.

13.1.3. Definition of Grievance

For purposes of this RFP, a **grievance** is defined as an expression of dissatisfaction about any matter other than an action, as "action" is defined in 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 grievances and appeals handled at the CCN level.

13.2. General Grievance System Requirements

13.2.1. Grievance System

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

13.2.2. Filing Requirements

13.2.2.1. Authority to File

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

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

13.2.3. Time Limits for Filing

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

13.2.4. Procedures for Filing

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

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

13.3. Notice of Grievance and Appeal Procedures

The CCN shall ensure that all CCN members are informed of the State Fair Hearing process and of the CCN's grievance and appeal procedures. The CCN shall provide to each member a member handbook that shall include descriptions of the CCN's grievance and appeal procedures. Forms on which members may file grievances, appeals, 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.

13.4. Grievance/Appeal Records and Reports

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

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

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

13.5. Handling of Grievances and Appeals

13.5.1. General Requirements

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

13.5.1.1. Acknowledge receipt of each grievance and appeal in writing;

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

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

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

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

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

13.5.2. Special Requirements for Appeals

The process for appeals must:

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

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

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

13.5.2.4. Include, as parties to the appeal:

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

13.5.3. Training of CCN Staff

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

13.5.4. Identification of Appropriate Party

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

13.5.5. Failure to Make a Timely Decision

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

13.5.6. Right to State Fair Hearing

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

13.6. Notice of Action

13.6.1. Language and Format Requirements

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

13.6.2. Content of Notice of Action

The Notice of Action must explain the following:

13.6.2.1. The action the CCN or its contractor has taken or intends to take;

13.6.2.2. The reasons for the action;

13.6.2.3. The member's or the provider's right to file an appeal with the CCN;

13.6.2.4. The member's right to request a State Fair Hearing, after the CCN's appeal process has been exhausted;

13.6.2.5. The procedures for exercising the rights specified in this section

13.6.2.6. The circumstances under which expedited resolution is available and how to request it; and

13.6.2.7. The member's right to have benefits continued pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services.

13.6.3. Timing of Notice of Action

The CCN must mail the Notice of Action within the following timeframes:

13.6.3.1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action, except as permitted under 42 C.F.R. §§ 431.213 and 431.214:

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

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

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

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

13.6.3.4. If the CCN extends the timeframe in accordance with § **13.11.3.3.1** or **13.11.3.3.2** above, it must:

13.6.3.4.1. 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

13.6.3.4.2. Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

13.6.3.5. On the date the timeframe for service authorization as specified in **§ 13.11.3.3** expires.

13.6.3.6. 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.

13.6.3.7. 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 interest.

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

13.7. Resolution and Notification

The CCN must dispose of a grievance and resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within the timeframes established in **§ 13.12.1** below.

13.7.1. Specific Timeframes

13.7.1.1. Standard Disposition of Grievances

For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety (90) days from the day the CCN receives the grievance.

13.7.1.2. Standard Resolution of Appeals

For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the CCN receives the appeal. This timeframe may be extended under **§ 13.12.4** of this section.

13.7.1.3. Expedited Resolution of Appeals

For expedited resolution of an appeal and notice to affected parties, the timeframe is established as seventy-two (72) hours after the CCN receives the appeal. This timeframe may be extended under **§ 13.12.4** of this Section.

13.7.2. Extension of Timeframes

13.7.2.1. The CCN may extend the timeframes from **§ 13.12.1** of this section by up to fourteen (14) calendar days if:

13.7.2.1.1. The member requests the extension; or

13.7.2.1.2. 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.

13.7.2.2. Requirements Following Timeframe 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.

13.7.3. Format of Notice of Disposition

13.7.3.1. Grievances

DHH will specify the method the CCN will use to notify a member of the disposition of a grievance.

13.7.3.2. Appeals

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

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

13.7.4. Content of Notice of Appeal Resolution

The written notice of the resolution must include the following:

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

13.7.4.2. For appeals not resolved wholly in favor of the members:

13.7.4.2.1. The right to request a State Fair Hearing, and how to do so;

13.7.4.2.2. The right to request to receive benefits while the hearing is pending, and how to make the request; and

13.7.4.2.3. That the member may be held liable for the cost of those benefits if the hearing decision upholds the CCN's action.

13.7.5. Requirements for State Fair Hearings

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

13.7.5.1. Availability

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

13.7.5.2. 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.

13.8. Expedited Resolution of Appeals

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

13.8.1. Prohibition Against Punitive Action

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

13.8.2. Action Following Denial of a Request for Expedited Resolution

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

13.8.2.1. Transfer the appeal to the timeframe for standard resolution in accordance with Section § 13.12.1.2;

13.8.2.2. Make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

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

13.8.3. Failure to Make a Timely Decision

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

13.8.4. Process

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

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

13.8.5. Authority to File

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

13.8.6. Format of Resolution Notice

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

13.9. Continuation of Benefits

13.9.1. Terminology

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

13.9.1.1. Within ten (10) days of the CCN mailing the notice of action.

13.9.1.2. The intended effective date of the CCN's proposed action.

13.9.2. Continuation of Benefits

The CCN must continue the member's benefits if:

13.9.2.1. The member or the provider, acting on behalf of the member and with the member's written consent, files the appeal timely;

13.9.2.2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

13.9.2.3. The services were ordered by an authorized provider;

13.9.2.4. The original period covered by the original authorization has not expired; and

13.9.2.5. The member requests extension of benefits.

13.9.3. Duration of Continued or Reinstated Benefits

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

13.9.3.1. The member withdraws the appeal.

13.9.3.2. Ten (10) days pass after the CCN mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached.

13.9.3.3. A State Fair Hearing Officer issues a hearing decision adverse to the member.

13.9.3.4. The time period or service limits of a previously authorized service has been met.

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

If the final resolution of the appeal is adverse to the member, that is, upholds the CCN's action, the CCN 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 C.F.R. § 431.230(b).

13.10. Information to Providers and Contractors

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

13.11. Recordkeeping and Reporting Requirements

Reports of grievances and resolutions shall be submitted to DHH as specified in **§13.9 and** of this RFP. The CCN shall not modify the grievance procedure without the prior written approval of DHH.

13.12. Effectuation of Reversed Appeal Resolutions

13.12.1. Services not Furnished While the Appeal is Pending

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

13.12.2. Services Furnished While the Appeal is Pending

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

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14.0 QUALITY MANAGEMENT

14.1. Quality Assessment and Performance Improvement Program (QAPI)

14.1.1. The CCN shall establish and implement a Quality Assessment and Performance Improvement (QAPI) program, as required by 42 CFR §438.240(a)(1), to:

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

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

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

14.1.1.3. Detect underutilization and overutilization of services

14.1.1.4. Assess the quality and appropriateness of care furnished to enrollees with special health care needs.

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

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

14.1.4. The CCN shall submit its QAPI Program description to DHH for written approval within thirty (30) days from the date the Contract is signed.

14.1.5. 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.

14.2. QAPI Committee

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

14.2.1. QAPI Committee Members

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

14.2.1.2. Appropriate CCN staff representing the various departments of the organization will have membership on the committee; and

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

14.2.2. QAPI Committee Responsibilities

14.2.2.1. The committee shall meet on a quarterly basis

14.2.2.2. Direct and review quality improvement (QI) activities;

14.2.2.3. Assure than QAPI activities are implemented throughout the CCN;

14.2.2.4. Review and suggest new and or improved QI activities;

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

14.2.2.6. Designate evaluation and study design procedures;

14.2.2.7. Conduct individual PCP and PCP practice quality performance measure profiling;

14.2.2.8. Report findings to appropriate executive authority, staff, and departments within the CCN;

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

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

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

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

14.2.3. QAPI Work Plan

The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan shall be submitted to DHH within thirty (30) days from the date the Contract with DHH is signed by the CCN and annually thereafter, and prior to revisions. The QAPI plan, at a minimum, shall:

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

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

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

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

14.2.4. QAPI Reporting Requirements

14.2.4.1. The CCN shall submit QAPI reports annually to DHH which, at a minimum, shall include:

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

14.2.4.2. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than sixty (60) days prior to due date of those reports.

14.3. Performance Measures

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

14.3.1.1. The CCN is required to report on PMs listed in Appendix J 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.

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

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

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

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

14.3.2. Incentive Based Performance Measures

14.3.2.1. Incentive Based (IB) measures are Level I measures that may affect PMPM payments and can be identified in Appendix J annotated with "$".

14.3.2.2. Based on a CCN's Performance Measure outcomes for CYE 12/31/2013, a maximum of 2.5% (0.5% for each of 5 specific IB measures) of the total monthly capitation payments may be deducted effective October following the measurement CY if specified performance measures fall below DHH's established benchmarks for improvement.

14.3.2.3. 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.

14.3.3. Performance Reporting Measures

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

- Administrative measure reporting is required semiannually and upon DHH request.
- 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.
- 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.
- 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.
- Level I and Level II PM reporting is required annually, and upon DHH request, beginning in 2014 utilizing CY 2013 data for Contracts that begin after January 1, 2012.

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

14.3.4. Performance Measure Goals

14.3.4.1. 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.

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

14.3.5. Performance Measure Reporting

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

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

14.3.5.3. The CCN shall have processes in place to monitor and self-report performance measures as specified in §14.3.3 Reporting Measures.

14.3.5.4. The CCN shall provide individual PCP clinical quality profile reports as indicated in §8.22 PCP Utilization and Quality Reporting.

14.3.6. Performance Measure Monitoring

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

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

14.3.6.3. 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.

14.3.6.4. 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. DHH must prior approve the CAP and will monitor the CCN's progress in correcting the deficiencies.

14.3.7. Performance Measure Corrective Action Plan

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

14.3.7.1. The CCN shall submit a CAP, within thirty (30) calendar days of the date of notification or as specified by DHH, for the deficiencies identified by DHH.

14.3.7.2. 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 deficiencies identified by DHH.

14.3.7.3. 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.

14.3.7.4. DHH may impose liquidated damages, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.

14.3.8. Performance Improvement Projects

14.3.8.1. 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.

14.3.8.2. 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 DD - **Performance Improvement Projects.** The CCN shall choose the second PIP from Section 2 of Appendix DD. DHH may require an additional PIP each successive year to reach a maximum of four (4) PIPs.

14.3.8.3. 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:

- Measurement of performance using objective quality indicators;
- Implementation of system interventions to achieve improvement in quality;
- Evaluation of the effectiveness of the interventions; and
- Planning and initiation of activities for increasing or sustaining improvement.

14.3.8.4. 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:

- An overview explaining how and why the project was selected, as well as its relevance to the CCN members and providers;
- The study question;

- The study population;
- The quantifiable measures to be used, including a goal or benchmark;
- Baseline methodology;
- Data sources;
- Data collection methodology and plan;
- Data collection cycle;
- Data analysis cycle and plan;
- Results with quantifiable measures;
- Analysis with time period and the measures covered;
- Analysis and identification of opportunities for improvement; and
- An explanation of all interventions to be taken.

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

- Target specific conditions and specific health service delivery issues for focused system-wide and individual practitioner monitoring and evaluation;
- 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;
- Use appropriate quality indicators derived from the clinical care standards and/or practice guidelines to screen and monitor care and services delivered;
- Implement system interventions to achieve improvement in quality;
- Evaluate the effectiveness of the interventions;
- Provide sufficient information to plan and initiate activities for increasing or sustaining improvement;
- Monitor the quality and appropriateness of care furnished to enrollees with special health care needs;

- Reflect the population served in terms of age groups, disease categories, and special risk status,
- Ensure that appropriate health professionals analyze data;
- Ensure that multi-disciplinary teams will address system issues;
- Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal benchmark;
- 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
- Maintain a system for tracking issues over time to ensure that actions for improvement are effective.

14.3.8.6. 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**.

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

14.3.8.8. 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.
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14.3.9. PIP Reporting Requirements

14.3.9.1. The CCN shall submit PIP outcomes annually to DHH.

14.3.9.2. Reporting specifications are detailed in the ***Quality Companion Guide***.

14.3.9.3. 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.

14.4. Member Satisfaction Surveys

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

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

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

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

14.4.4. The 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.

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

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

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

14.4.7.1. Getting Needed Care

14.4.7.2. Getting Care Quickly

14.4.7.3. How Well Doctors Communicate

14.4.7.4. Health Plan Customer Service

14.4.7.5. Global Ratings

14.4.8. Member Satisfaction Survey Reports are due 120 days after the end of the plan year.

14.5. Provider Satisfaction Surveys

14.5.1. The CCN shall conduct an annual provider survey to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, and utilization management processes, including medical reviews and support toward Patient Centered Medical Home implementation.

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

14.5.2. 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 120 days after the end of the plan year.

14.6. DHH Oversight of Quality

14.6.1. 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.

14.6.2. 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.

14.6.3. 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.

14.6.4. 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.

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

14.7. External Independent Review

14.7.1. The 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.

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

14.7.3. If the EQRO indicates that the quality of care is not within acceptable limits set forth in the Contract, DHH may sanction the CCN in accordance with the provisions of § 20 of the Contract 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.

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

14.8. Health Plan Accreditation

14.8.1. The CCN must attain health plan accreditation by NCQA or URAC. If the CCN is not currently accredited by NCQA or URAC, the CCN must attain accreditation by meeting NCQA or URAC's accreditation standards.

14.8.2. The CCN's application for accreditation must be submitted at the earliest point allowed by the organization. The CCN must provide DHH with a copy of all correspondence with NCQA or URAC regarding the application process and the accreditation requirements.

14.8.3. Achievement of provisional accreditation status shall require a CAP within thirty (30) calendar days of receipt of the Final Report from NCQA. Failure to obtain full NCQA or URAC accreditation and to maintain the accreditation thereafter shall be considered a breach of the Contract and shall result in termination of the Contract.

14.9. Credentialing and Re-credentialing of Providers and Clinical Staff

14.9.1. The CCN must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12; §438.206, §438.214, §438.224 and §438.230 and NCQA health plan Accreditation Standards for the review and credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. The CCN shall use the state's standardized credentialing form (see Appendix F – **Louisiana Standardized Credentialing Application Form**). An independent relationship exists when the CCN selects and directs it members to see a specific provider or group of providers. These procedures shall be submitted as part of the Proposal, when a change is made, and annually thereafter.

14.9.2. The process for periodic re-credentialing shall be implemented at least once every three (3) years.

14.9.3. If the CCN is not NCQA health plan accredited and has delegated credentialing to a subcontractor, there shall be a written description of the delegation of credentialing activities within the contract. The CCN must require that the subcontractor provide assurance that all licensed medical professionals are credentialed in accordance with DHH's credentialing requirements. DHH will have final approval of the delegated entity.

14.9.4. If the CCN has NCQA health plan Accreditation those credentialing policies and procedures shall meet DHH's credentialing requirements.

14.9.5. The CCN shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to assure compliance with the Contract. The policies and procedures should include but are not limited to the encouragement of applicable board certification.

14.9.6. The CCN shall develop and implement a mechanism, with DHH's approval, for reporting quality deficiencies which result in suspension or termination of a network provider/ subcontractor(s). This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.

14.9.7. The CCN shall develop and implement a provider dispute and appeal process, with DHH's approval, for sanctions, suspensions, and terminations imposed by the CCN against network provider/contractor(s) as specified in the Contract.

This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.

14.10. Member Advisory Council

14.10.1. 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.

14.10.2. The Council is to be chaired by the CCN's Administrator/CEO/COO or designee and will meet at least quarterly.

14.10.3. 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.

14.10.4. The CCN shall provide an orientation and ongoing training for Council members so they have sufficient information and understanding to fulfill their responsibilities.

14.10.5. 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.

14.10.6. 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.

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15.0 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 meet with DHH and the MFCU periodically, at DHH's request, to discuss fraud, abuse, neglect and overpayment issues. For purposes of this Section, the CCN's compliance officer shall be the point of contact for the CCN.

15.1.3. 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.

15.1.4. The CCN and its subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with CCN clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The 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.

15.1.5. CCN's employees and its contractors and their employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.

15.1.6. The 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).

15.1.7. The CCN shall certify all statements, reports and claims, 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.

15.1.8. 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. Fraud and Abuse Compliance Plan

15.2.1. In accordance with 42 CFR §438.608(a), the CCN shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in the administration and delivery of services.

15.2.2. In accordance with 42 CFR §438.608(b)(2), the CCN shall designate a compliance officer and compliance committee that have the responsibility and authority for carrying out the provisions of the compliance program. These individuals shall be accountable to the CCN's board of directors and shall be directly answerable to the Executive Director or to the board of directors and senior management. The CCN shall have an adequately staffed Medicaid compliance office with oversight by the compliance officer.

15.2.3. The CCN shall submit the Fraud and Abuse Compliance Plan within thirty (30) days from the date the Contract is signed. The CCN shall submit updates or modifications to DHH for approval at least thirty (30) days in advance of making them effective. DHH, at its sole discretion, may require that the CCN modify its compliance plan. The CCN compliance program shall incorporate the policy and procedures specified in Appendix EE – **Coordination of CCN Fraud and Abuse Complaints and Referrals** and incorporate the following:

15.2.3.1. Written policies, procedures, and standards of conduct that articulate CCN's commitment to comply with all applicable federal and state standards;

15.2.3.2. Effective lines of communication between the compliance officer and the CCN's employees, providers and contractors enforced through well-publicized disciplinary guidelines;

15.2.3.3. Procedures for ongoing monitoring and auditing of CCN systems, including, but not limited to, claims processing, billing and financial operations, enrollment functions, member services, continuous quality improvement activities, and provider activities;

15.2.3.4. Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the compliance officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel;

15.2.3.5. Provisions for internal monitoring and auditing reported fraud, abuse, and waste in accordance with 42 CFR §438.608(b)(4-6);

15.2.3.6. Protections to ensure that no individual who reports compliance plan violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the CCN. The CCN shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible. Anyone who believes that he or she has been retaliated against may report this violation to the Louisiana Medicaid Office of Program Integrity and/or the U.S. Office of Inspector General.

15.2.3.7. Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the Contract in accordance with 42 CFR §438.608(b)(7);

15.2.3.8. Well-publicized disciplinary procedures that shall apply to employees who violate the CCN compliance program;

15.2.3.9. Effective education for the compliance officer, managers, employees, providers and members to ensure that they know and understand the provisions of CCN's compliance plan;

15.2.3.10. Procedures for timely consistent exchange of information and collaboration with the DHH Program Integrity Unit; and

15.2.3.11. Provisions that comply with 42 CFR §438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' ***Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks***) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.

15.3. Prohibited Affiliations

15.3.1. In accordance with 42CFR 438.610, the CCN is prohibited from knowingly having a relationship with:

15.3.1.1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the federal acquisition regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The 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://exclusions.oig.hhs.gov/search.aspx ;

- Health Care Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.jsp ; and

- Excluded Parties List Serve (EPLS) www.EPLS.gov

15.3.1.2. The 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).

15.3.1.3. An individual who is an affiliate of a person described above and include:

- A director, officer, or partner of the CCN;

- A person with beneficial ownership of 5 percent or more of the CCN's equity; or

- 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.

15.3.1.4. 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.

15.4. Excluded Providers

Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for emergency services.

15.5. Reporting

15.5.1. In accordance with 42 CFR §455.1(a)(1) and §455.17, the CCN shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect information to the state's Office of Inspector General Medicaid Fraud Control Unit (MFCU), and DHH within five (5) business days of discovery, taking prompt corrective actions and cooperating with DHH in its investigation of the matter(s). Additionally, the 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.

15.5.2. The CCN, through its compliance officer, has an affirmative duty to report all activities on a quarterly basis to DHH. If fraud, abuse, waste, neglect and overpayment issues are suspected, the CCN compliance officer shall report it to DHH immediately upon discovery. Reporting shall include, but are not limited to:

15.5.2.1. Number of complaints of fraud, abuse, waste, neglect and overpayments made to the CCN that warrant preliminary investigation;

15.5.2.2. Number of complaints reported to the Compliance Officer; and

15.5.2.3. For each complaint that warrants investigation, the 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.

15.6. Medical Records

15.6.1. The CCN shall have a method to verify that services for which 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:

15.6.1.1. Accurate and legible;

15.6.1.2. Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all members evaluated or treated, and is accessible for review and audit; and

15.6.1.3. Readily available for review and provides medical and other clinical data required for Quality and Utilization Management review.

15.6.2. The CCN shall ensure the medical record includes, minimally, the following:

15.6.2.1. Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);

15.6.2.2. Primary language spoken by the member and any translation needs of the member;

15.6.2.3. Services provided through the CCN, date of service, service site, and name of service provider;

15.6.2.4. Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the CCN;

15.6.2.5. Referrals including follow-up and outcome of referrals;

15.6.2.6. Documentation of emergency and/or after-hours encounters and follow-up;

15.6.2.7. Signed and dated consent forms (as applicable);

15.6.2.8. Documentation of immunization status;

15.6.2.9. Documentation of advance directives, as appropriate;

15.6.2.10. 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.

15.6.2.11. 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.

15.6.3. The CCN is required to provide one (1) free copy of any part of member's record upon member's request.

15.6.4. All documentation and/or records maintained by the CCN or any and all of its network providers shall be maintained for at least six (6) years after the last good, service or supply has been provided to a member or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.

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16.0 SYSTEMS AND TECHNICAL REQUIREMENTS

16.1. General Requirements

16.1.1. The CCN shall maintain an automated Management Information System (MIS), hereafter referred to as System, which accepts and processes provider claims, verifies eligibility, collects and reports encounter data and validates prior authorization and pre-certification that complies with DHH and federal reporting requirements. The CCN shall ensure that its System meets the requirements of the Contract, state issued Guides (***See CCN-P Systems Guide***) and all applicable state and federal laws, rules and regulations, including Medicaid confidentiality and HIPAA and American Recovery and Reinvestment Act (ARRA) privacy and security requirements.

16.1.2. The CCN's application systems foundation shall employ the relational data model in its database architecture, which would entail the utilization of a relational database management system (RDBMS) such as Oracle®, DB2®, or SQL Server®. It is important that the CCN's application systems support query access using Structured Query Language (SQL). Other standard connector technologies, such as Open Database Connectivity (ODBC) and/or Object Linking and Embedding (OLE), are desirable.

16.1.3. All the CCN's applications, operating software, middleware, and networking hardware and software shall be able to interoperate as needed with DHH's systems and shall conform to applicable standards and specifications set by DHH.

16.1.4. The CCN's System shall have, and maintain, capacity sufficient to handle the workload projected for the begin date of operations and shall be scalable and flexible so that it can be adapted as needed, within negotiated timeframes, in response to changes in the Contract requirements.

16.2. HIPAA Standards and Code Sets

16.2.1. The System shall be able to transmit, receive and process data in current HIPAA-compliant or DHH specific formats and/or methods, including, but not limited to, secure File Transfer Protocol (FTP) over a secure connection such as a Virtual Private Network (VPN), that are in use at the start of Systems readiness review activities. Data elements and file format requirements may be found in the CCN-P Systems Companion Guide.

16.2.2. All HIPAA-conforming exchanges of data between DHH and the CCN shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker. The **HIPAA Business Associate Agreement** (Appendix C) shall become a part of the Contract.

16.2.3. The System shall conform to the following HIPAA-compliant standards for information exchange. Batch transaction types include, but are not limited to, the following:

16.2.3.1. ASC X12N 834 Benefit Enrollment and Maintenance;

16.2.3.2. ASC X12N 835 Claims Payment Remittance Advice Transaction;

16.2.3.3. ASC X12N 837I Institutional Claim/Encounter Transaction;

16.2.3.4. ASC X12N 837P Professional Claim/Encounter Transaction;

16.2.3.5. ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;

16.2.3.6. ASC X12N 276 Claims Status Inquiry;

16.2.3.7. ASC X12N 277 Claims Status Response;

16.2.3.8. ASC X12N 278/279 Utilization Review Inquiry/Response; and

16.2.3.9. ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products.

16.2.4. The CCN shall not revise or modify the standardized forms or formats.

16.2.5. Transaction types are subject to change and the CCN shall comply with applicable federal and HIPAA standards and regulations as they occur.

16.2.6. 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, federal safeguard requirements including signature requirements described in the CMS State Medicaid Manual.

16.3. Connectivity

16.3.1. DHH is requiring that the CCN interface with DHH, the Medicaid Fiscal Intermediary (FI), the Enrollment Broker (EB) and its trading partners. The CCN must have capacity for real time connectivity to all DHH approved systems.

16.3.2. The System shall conform and adhere to the data and document management standards of DHH and its FI, inclusive of standard transaction code sets.

16.3.3. The CCN's Systems shall utilize mailing address standards in accordance with the United States Postal Service.

16.3.4. At such time that DHH requires, the 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).

16.3.5. 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.

16.3.6. 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.

16.3.7. All information, whether data or documentation and reports that contain or references to that information involving or arising out of the Contract is owned

by DHH. The 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.

16.3.8. The Medicaid Management Information System (MMIS) processes claims and payments for covered Medicaid services. DHH's current MMIS contract expired December 31, 2010. DHH exercised 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 should DHH contract with a new FI during the Contract at no cost to DHH or its FI.

16.3.9. The CCN shall be responsible for all initial and recurring costs required for access to DHH system(s), as well as DHH access to the CCN's system(s). These costs include, but are not limited to, hardware, software, licensing, and authority/permission to utilize any patents, annual maintenance, support, and connectivity with DHH, the Fiscal Intermediary (FI) and the Enrollment Broker.

16.3.10. The CCN shall complete an Information Systems Capabilities Assessment (ISCA), which will be provided by DHH. The ISCA shall be completed and returned to DHH no later than thirty (30) days from the date the CCN signs the Contract with DHH.

16.3.11. Hardware and Software

The CCN must maintain hardware and software compatible with current DHH requirements which are as follows:

16.3.11.1. 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 800 x 640 screen resolution;
- A DVD +/-RW and CD-ROM drive capable of reading and writing to both media;
- 1 gigabyte Ethernet card;
- Enough spare USB ports to accommodate thumb drives, etc.; and
- Printer compatible with hardware and software required.

16.3.11.2. Desktop Workstation Software:

- Operating system should be Microsoft Windows XP SP3 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 or later;

- Each workstation should have access to high speed Internet;

- 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;

- A desktop compression/encryption application that is compatible with WinZIP v11.0;

- All workstations, laptops and portable communication devices shall be installed with full disk encryption software; and

- Compliant with industry-standard physical and procedural safeguards for confidential information (NIST 800-53A, ISO 17788, etc.).

16.3.11.3. Network and Back-up Capabilities

- Establish a local area network or networks as needed to connect all appropriate workstation personal desktop computers (PCs);

- Establish appropriate hardware firewalls, routers, and other security measures so that the CCN's computer network is not able to be breached by an external entity;

- Establish appropriate back-up processes that ensure the back-up, archival, and ready retrieval of network server data and desktop workstation data;

- Ensure that network hardware is protected from electrical surges, power fluctuations, and power outages by using the appropriate uninterruptible power system (UPS) and surge protection devices; and

- The CCN shall establish independent generator back-up power capable of supplying necessary power for four (4) days.

16.4. Resource Availability and Systems Changes

16.4.1. Resource Availability

The CCN shall provide Systems Help Desk services to DHH, its FI, and Enrollment Broker staff that have direct access to the data in the CCN's Systems.

16.4.1.1. The Systems Help Desk shall:

- 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;

- Answer questions regarding the CCN's System functions and capabilities; report recurring programmatic and operation problems to appropriate staff for follow-up; redirect problems or queries that are not supported by the Systems Help Desk, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate DHH staff;

- Ensure individuals who place calls after hours are have the option to leave a message. The CCN's staff shall respond to messages left between the hours of 7p.m. and 7a.m. by noon that next business day;

- Ensure recurring problems not specific to Systems unavailability identified by the Systems Help Desk shall be documented and reported to CCN management within one (1) business day of recognition so that deficiencies are promptly corrected; and

- Have an IS service management system that provides an automated method to record, track and report all questions and/or problems reported to the Systems Help Desk.

16.4.2. Information Systems Documentation Requirements

16.4.2.1. The CCN shall ensure that written Systems process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.

16.4.2.2. The CCN shall develop, prepare, print, maintain, produce, and distribute to DHH distinct Systems design and management manuals, user manuals and quick reference Guides, and any updates.

16.4.2.3. The CCN shall ensure the Systems user manuals contain information about, and instruction for, using applicable Systems functions and accessing applicable system data.

16.4.2.4. The CCN shall ensure when a System change is subject to DHH prior written approval, the CCN will submit revision to the appropriate manuals before implementing said Systems changes.

16.4.2.5. The CCN shall ensure all aforementioned manuals and reference Guides are available in printed form and on-line; and

16.4.2.6. The CCN shall update the electronic version of these manuals immediately, and update printed versions within ten (10) business days of the update taking effect.

16.4.2.7. The CCN shall provide to DHH documentation describing its Systems Quality Assurance Plan.

16.4.3. Systems Changes

16.4.3.1. The CCN's Systems shall conform to future federal and/or DHH specific standards for encounter data exchange within one hundred twenty (120) calendar days prior to the standard's effective date or earlier, as directed by CMS or DHH.

16.4.3.2. If a system update and/or change are necessary, the CCN shall draft appropriate revisions for the documentation or manuals, and present to DHH thirty (30) days prior to implementation, for DHH review and approval. Documentation revisions shall be accomplished electronically and shall be made available for Department review in an easily accessible, near real-time method. Printed manual revisions shall occur within ten (10) business days of the actual revision.

16.4.3.3. The CCN shall notify DHH staff of the following changes to its System within its span of control at least ninety (90) calendar days prior to the projected date of the change:

16.4.3.4. Major changes, upgrades, modification or updates to application or operating software associated with the following core production System:

- Claims processing;
- Eligibility and enrollment processing;
- Service authorization management;
- Provider enrollment and data management; and
- Conversions of core transaction management Systems.

16.4.3.5. 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's Systems 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's Systems.

16.4.3.6. Unless otherwise agreed to in advance by DHH, the CCN shall not schedule Systems unavailability to perform system maintenance, repair and/or upgrade activities to take place during hours that can compromise or prevent critical business operations.

16.4.3.7. 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's System.

16.5. Systems Refresh Plan

16.5.1. The CCN shall provide to DHH an annual Systems 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.

16.5.2. The systems refresh plan shall also indicate how the CCN will ensure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the Systems component.

16.6. Other Electronic Data Exchange

16.6.1. The CCN's 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, 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

16.6.2. The CCN shall implement Optical Character Recognition (OCR) technology that minimizes manual indexing and automates the retrieval of scanned documents.

16.7. Electronic Messaging

16.7.1. 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 (currently 2007) and any subsequent upgrades as adopted.

16.7.2. As needed, the CCN shall be able to communicate with DHH over a secure Virtual Private Network (VPN).

16.7.3. The CCN shall comply with national standards for submitting public health information (PHI) electronically and shall set up a secure emailing system with that is password protected for both sending and receiving any personal health information.

16.8. Eligibility and Enrollment Data Exchange

The CCN shall:

16.8.1. Receive, process and update enrollment files sent daily by the Enrollment Broker;

16.8.2. Update its eligibility and enrollment databases within twenty-four (24) hours of receipt of said files;

16.8.3. Transmit to DHH, in the formats and methods specified by DHH, member address changes and telephone number changes;

16.8.4. Be capable of uniquely identifying (i.e., Master Patient Index) a distinct Medicaid member across multiple populations and Systems within its span of control; and

16.8.5. Be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by DHH, resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

16.9. Provider Enrollment

At the onset of the CCN Contract and periodically as changes are necessary, DHH shall publish at the url: www.lamedicaid.com the list of Louisiana Medicaid provider types, specialty, and sub-specialty codes. The CCN shall utilize these codes within their provider enrollment system. The objective is to coordinate the provider enrollment records of the CCN with the same provider type, specialty and sub-specialty codes as those used by DHH and the Enrollment Broker. The CCN shall:

16.9.1. Provider name, address, licensing information, Tax ID, National Provider Identifier (NPI), taxonomy and payment information;

16.9.2. All relevant provider ownership information as prescribed by DHH, federal or state laws; and

16.9.3. Performance of all federal or state mandated exclusion background checks on all providers (owners and managers). The providers shall perform the same for all their employees at least annually.

16.9.4. Provider enrollment systems shall include, at minimum, the following functionality:

- Audit trail and history of changes made to the provider file;
- Automated interfaces with all licensing and medical boards;

- Automated alerts when provider licenses are nearing expiration;
- Retention of NPI requirements;
- System generated letters to providers when their licenses are nearing expiration;
- Linkages of individual providers to groups;
- Credentialing information;
- Provider office hours; and
- Provider languages spoken.

16.10. Information Systems Availability

The CCN shall:

16.10.1. Not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the CCN's span of control;

16.10.2. 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 data for the purpose of data mining and review;

16.10.3. Ensure that critical member and provider Internet and/or telephone-based IVR functions and information functions are available to the applicable System users twenty-four (24) hours a day, seven (7) days a week except during periods of scheduled System unavailability agreed upon by DHH and the CCN. Unavailability caused by events outside of the CCN's span of control is outside of the scope of this requirement;

16.10.4. Ensure that at a minimum all other System functions and information are available to the applicable system users between the hours of 7a.m. and 7p.m., Central Time, Monday through Friday;

16.10.5. Ensure that the systems and processes within its span of control associated with its data exchanges with DHH's FI and/or Enrollment Broker and its contractors are available and operational;

16.10.6. Ensure that in the event of a declared major failure or disaster, the CCN's core eligibility/enrollment and claims processing system shall be back on line within seventy-two (72) hours of the failure's or disaster's occurrence;

16.10.7. Notify designated DHH staff via phone, fax and/or electronic mail within sixty (60) minutes upon discovery of a problem within or outside the 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 or DHH's FI. In its notification, the CCN shall explain in detail the impact to critical path processes such as enrollment management and encounter submission processes;

16.10.8. Notify designated DHH staff via phone, fax, and/or electronic mail within fifteen (15) minutes upon discovery of a problem that results in delays in report distribution or problems in on-line access to critical systems functions and information during a business day, in order for the applicable work activities to be rescheduled or handled based on System unavailability protocol;

16.10.9. Provide information on System unavailability events, as well as status updates on problem resolution, to appropriate DHH staff. At a minimum these updates shall be provided on an hourly basis and made available via phone and/or electronic mail, and;

16.10.10. Resolve and implement system restoration within sixty (60) minutes of official declaration of unscheduled System unavailability of critical functions caused by the failure of system and telecommunications technologies within the 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.

16.10.10.1. Cumulative Systems 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; and

16.10.11. 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.

16.11. Contingency Plan

16.11.1. The CCN, regardless of the architecture of its Systems, shall develop and be continually ready to invoke, a contingency plan to protect the availability, integrity, and security of data during unexpected failures or disasters, (either natural or man-made) to continue essential application or system functions during or immediately following failures or disasters.

16.11.2. Contingency plans shall include a disaster recovery plan (DRP) and a business continuity plan (BCP). A DRP is designed to recover systems, networks, workstations, applications, etc. in the event of a disaster. A BCP shall focus on restoring the operational function of the organization in the event of a disaster and includes items related to IT, as well as operational items such as employee notification processes and the procurement of office supplies needed to do business in the emergency mode operation environment. The practice of including both the DRP and the BCP in the contingency planning process is a best practice.

16.11.3. The CCN shall have a Contingency Plan that must be submitted to DHH for approval no later than thirty (30) days from the date the Contract is signed.

16.11.4. At a minimum, the Contingency Plan shall address the following scenarios:

16.11.4.1. The central computer installation and resident software are destroyed or damaged;

16.11.4.2. 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;

16.11.4.3. System interruption or failure resulting from network, operating hardware, software or operations errors that compromise the integrity of data maintained in a live or archival system;

16.11.4.4. System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system, but does prevent access to the System, such as it causes unscheduled System unavailability; and

16.11.4.5. The Plan shall specify projected recovery times and data loss for mission-critical Systems in the event of a declared disaster.

16.11.5. The CCN shall annually test its plan through simulated disasters and lower level failures in order to demonstrate to DHH that it can restore Systems functions.

16.11.6. In the event the CCN fails to demonstrate through these tests that it can restore Systems 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.

16.12. Off Site Storage and Remote Back-up

16.12.1. The CCN shall provide for off-site storage and a remote back-up of operating instructions, procedures, reference files, system documentation, and operational files.

16.12.2. The data back-up policy and procedures shall include, but not be limited to:

16.12.2.1. Descriptions of the controls for back-up processing, including how frequently back-ups occur;

16.12.2.2. Documented back-up procedures;

16.12.2.3. The location of data that has been backed up (off-site and on-site, as applicable);

16.12.2.4. Identification and description of what is being backed up as part of the back-up plan; and

16.12.2.5. Any change in back-up procedures in relation to the CCN's technology changes.

16.12.3. DHH shall be provided with a list of all back-up files to be stored at remote locations and the frequency with which these files are updated.

16.13. Records Retention

16.13.1. The CCN shall have online retrieval and access to documents and files for six (6) years in live systems for audit and reporting purposes, ten (10) years in archival systems. Services which have a once in a life-time indicator (i.e., appendix removal, hysterectomy) are denoted on DHH's procedure formulary file and claims shall remain in the current/active claims history that is used in claims editing and are not to be archived or purged. Online access to claims processing data shall be by the Medicaid recipient ID, provider ID and/or ICN (internal control number) to include pertinent claims data and claims status. The CCN shall provide forty-eight (48) hour turnaround or better on requests for access to information that is six (6) years old, and seventy-two (72) hour turnaround or better on requests for access to information in machine readable form, that is between six (6) to ten (10) years old. If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.

16.13.2. The historical encounter data submission shall be retained for a period not less than six (6) years, following generally accepted retention guidelines.

16.13.3. Audit Trails shall be maintained online for no less than six (6) years; additional history shall be retained for no less than ten (10) years and shall be provide forty-eight (48) hour turnaround or better on request for access to information in machine readable form, that is between six (6) to ten (10) years old.

16.14. Information Security and Access Management

The CCN's system shall:

16.14.1. Employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

16.14.1.1. Restrict access to information on a "least privilege" basis, such as users permitted inquiry privileges only, will not be permitted to modify information;

16.14.1.2. 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

16.14.1.3. Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.

16.14.2. Make System information available to duly authorized representatives of DHH and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

16.14.3. Contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed by the CCN and DHH.

16.14.4. Ensure that audit trails be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:

16.14.4.1. Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

16.14.4.2. Have the date and identification "stamp" displayed on any on-line inquiry;

16.14.4.3. Have the ability to trace data from the final place of recording back to its source data file and/or document;

16.14.4.4. Be supported by listings, transaction reports, update reports, transaction logs, or error logs; and

16.14.4.5. Facilitate auditing of individual records as well as batch audits.

16.14.5. Have inherent functionality that prevents the alteration of finalized records;

16.14.6. 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;

16.14.7. Restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access;

16.14.8. Include physical security features designed to safeguard processor sites through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel;

16.14.9. Put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of a CCN's span of control. This includes, but is not limited to, any provider or

member service applications that are directly accessible over the Internet, shall be appropriately isolated to ensure appropriate access;

16.14.10. Ensure that remote access users of its Systems can only access said Systems through two-factor user authentication and via methods such as Virtual Private Network (VPN), which must be prior approved by DHH no later than fifteen (15) calendar days after the Contract award; and

16.14.11. Comply with recognized industry standards governing security of state and federal automated data processing systems and information processing. As a minimum, the CCN shall conduct a security risk assessment and communicate the results in an information security plan provided no later than fifteen (15) calendar days after the Contract award. The risk assessment shall also be made available to appropriate federal agencies.

16.15. Audit Requirements

16.15.1. The CCN shall ensure that their Systems facilitate the auditing of individual claims. Adequate audit trails shall be provided throughout the Systems. To facilitate claims auditing, the CCN shall ensure that the Systems follows, at a minimum, the guidelines and objectives of the American Institute of Certified Public Accountants (AICPA) *Audit and Account Guide, The Auditor's Study and Evaluation of Internal Control in Electronic Data Processing (EDP) Systems*.

16.15.2. 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.

16.16. State Audits

16.16.1. 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.

16.16.2. 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.

16.16.3. At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the state auditors. These findings shall be reviewed by DHH and integrated into the CCN's EDP manual.

16.17. Independent Audit

16.17.1. The CCN shall be required to contract with an independent firm, subject to the written approval of DHH, which has experience in conducting EDP and compliance audits in accordance with applicable federal and state auditing standards for applications comparable with the scope of the Contract's Systems application. The independent firm shall:

16.17.1.1. 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

16.17.1.2. Perform a comprehensive audit on an annual basis to determine the CCN's compliance with the obligations specified in the Contract and the Systems Guide.

16.17.2. 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.

16.17.3. DHH shall use the findings and recommendations of each report as part of its monitoring process.

16.17.4. 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.

16.17.5. 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).

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17.0 CLAIMS MANAGEMENT

17.1. Electronic Claims Management (ECM) Functionality

17.1.1. The CCN shall annually comply with DHH's Electronic Claims Data Interchange policies for certification of electronically submitted claims.

17.1.2. To the extent that the CCN compensates providers on a fee-for-service or other basis requiring the submission of claims as a condition of payment, the CCN shall process the provider's claims for covered services provided to members, consistent with applicable CCN policies and procedures and the terms of the Contract and the Systems Guide, including, but not limited to, timely filing, and compliance with all applicable state and federal laws, rules and regulations.

17.1.3. The CCN shall maintain an electronic claims management system that will:

17.1.3.1. Uniquely identify the attending and billing provider of each service;

17.1.3.2. Identify the date of receipt of the claim (the date the CCN receives the claim and encounter information);

17.1.3.3. Identify real-time accurate history with dates of adjudication results of each claim such as paid, denied, suspended, appealed, etc., and follow up information on appeals;

17.1.3.4. Identify the date of payment, the date & number of the check or other form of payment such as electronic funds transfer (EFT);

17.1.3.5. Identify all data elements as required by DHH for encounter data submission as stipulated in this Section of the RFP and the Systems Guide; and

17.1.3.6. Allow submission of non-electronic and electronic claims by contracted providers.

17.1.4. The CCN shall ensure that an electronic claims management (ECM) capability that accepts and processes claims submitted electronically is in place.

17.1.5. The CCN shall ensure the ECM system shall function in accordance with information exchange and data management requirements as specified in this Section of the RFP and the Systems Guide.

17.1.6. The CCN shall ensure that as part of the ECM function it can provide on-line and phone-based capabilities to obtain processing status information.

17.1.7. The CCN shall support an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

17.1.8. The CCN shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the CCN or a third party. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable transaction fees and/or charges.

17.1.9. The CCN shall require that their providers comply at all times with standardized billing forms and formats, and all future updates for Professional claims (CMS 1500) and Institutional claims (UB 04).

17.1.10. The CCN must comply with requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010, regarding "Mandatory State Use of National Correct Coding Initiatives," including all applicable rules, regulations, and methodologies implemented as a result of this initiative.

17.1.11. The 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.

17.1.12. The CCN shall have procedures approved by DHH, available to providers in written and web form for the acceptance of claim submissions which include:

17.1.12.1. The process for documenting the date of actual receipt of non-electronic claims and date and time of electronic claims;

17.1.12.2. The process for reviewing claims for accuracy and acceptability;

17.1.12.3. The process for prevention of loss of such claims, and

17.1.12.4. The process for reviewing claims for determination as to whether claims are accepted as clean claims.

17.1.13. The CCN shall have a procedure approved by DHH available to providers in written and web form for notifying providers of batch rejections. The report, at a minimum, should contain the following information:

17.1.13.1. Date batch was received by the CCN;

17.1.13.2. Date of rejection report;

17.1.13.3. Name or identification number of CCN issuing batch rejection report;

17.1.13.4. Batch submitters name or identification number; and

17.1.13.5. Reason batch is rejected.

17.1.14. The CCN shall assume all costs associated with claim processing, including the cost of reprocessing/resubmission, due to processing errors caused by the CCN or to the design of systems within the CCN's span of control.

17.1.15. The CCN shall not employ off-system or gross adjustments when processing correction to payment error, unless it requests and receives prior written authorization from DHH.

17.1.16. For purposes of network management, the CCN shall notify all contracted providers to file claims associated with covered services directly with the CCN, or its contractors, on behalf of Louisiana Medicaid members.

17.1.17. At a minimum, the CCN shall run one (1) provider payment cycle per week, on the same day each week, as determined by the CCN and approved by DHH.

17.2. Claims Processing Methodology Requirements

The CCN shall perform system edits, including, but not limited to:

17.2.1. Confirming eligibility on each member as claims are submitted on the basis of the eligibility information provided by DHH and the Enrollment Broker that applies to the period during which the charges were incurred;

17.2.2. A review of the entire claim within five (5) working days of receipt of an electronic claim, to determine that the claim is not a clean claim and issue an exception report to the provider indicating all defects or reasons known at that time that the claim is not a clean claim. The exception report shall contain at a minimum the following information:

17.2.2.1. Member name;

17.2.2.2. Provider claim number, patient account number, or unique member identification number;

17.2.2.3. Date of service;

17.2.2.4. Total billed charges;

17.2.2.5. CCN's name; and

17.2.2.6. The date the report was generated.

17.2.3. Medical necessity;

17.2.4. Prior Approval – The system shall determine whether a covered service required prior approval and if so, whether the CCN granted such approval;

17.2.5. Duplicate Claims – The system shall in an automated manner, flag a claim as being exactly the same as a previously submitted claim or a possible duplicate and either deny or pend the claim as needed;

17.2.6. Covered Services - Ensure that the system verify that a service is a covered service and is eligible for payment;

17.2.7. Provider Validation - Ensure that the system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted;

17.2.8. Quantity of Service - Ensure that the system shall evaluate claims for services provided to members to ensure that any applicable benefit limits are applied;

17.2.9. Perform system edits for valid dates of service, and assure that dates of services are valid dates such as not in the future or outside of a member's Medicaid eligibility span;

17.2.10. Perform post-payment review on a sample of claims to ensure services provided were medically necessary; and

17.2.11. Have a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity.

17.3. Explanation of Benefits (EOBs)

17.3.1. The CCN shall within forty-five (45) days of payment of claims, provide individual notices to a sample group of the members who received services. The required notice must specify:

17.3.1.1.1. The service furnished;

17.3.1.1.2. The name of the provider furnishing the service;

17.3.1.1.3. The date on which the service was furnished; and

17.3.1.1.4. The amount of the payment made for the service.

17.3.2. The CCN shall also:

17.3.2.1. Include in the sample, claims for services with hard benefit limits, denied claims with member responsibility, and paid claims (excluding ancillary and anesthesia services).

17.3.2.2. Stratify paid claims sample to ensure that all provider types (or specialties) are represented in the pool of generated EOBs. To the extent that the CCN considers a particular specialty (or provider) to warrant closer scrutiny, the CCN may over sample the group. The paid claims sample should be a minimum of two hundred (200) to two hundred-fifty (250) claims per year.

17.3.3. The CCN shall track any complaints received from members and resolve the complaints according to its established policies and procedures. The resolution may be member education, provider education, or referral to DHH. The CCN shall use the feedback received to modify or enhance the EOB sampling methodology.

17.4. Remittance Advices

In conjunction with its payment cycles, the CCN shall provide:

17.4.1. Each remittance advice generated by the CCN to a provider shall, if known at that time, clearly identify for each claim, the following information:

17.4.1.1. The name of the member;

17.4.1.2. Unique member identification number;

17.4.1.3. Patient claim number or patient account number;

17.4.1.4. Date of service;

17.4.1.5. Total provider charges;

17.4.1.6. Member liability, specifying any co-insurance, deductible, co-payment, or non-covered amount;

17.4.1.7. Amount paid by the CCN;

17.4.1.8. Amount denied and the reason for denial; and

17.4.1.9. In accordance with 42 CFR §§ 455.18 and 455.19, the following statement shall be included on each remittance advice sent to providers: " I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws."

17.5. Adherence to Key Claims Management Standards

17.5.1. Prompt Payment to Providers

17.5.1.1. The CCN shall ensure that ninety percent (90%) of all clean claims for payment of services delivered to a member are paid by the CCN to the provider within fifteen (15) business days of the receipt of such claims.

17.5.1.2. The CCN shall process and, if appropriate, pay within thirty (30) calendar days, ninety-nine percent (99%) of all clean claims to providers for covered services delivered to a member.

17.5.1.3. If a clean claim is denied on the basis the provider did not submit required information or documentation with the claim, then the remittance advice shall specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall not constitute a new claim for purposes of establishing the timeframe for timely filing.

17.5.1.4. To the extent that the provider contract requires compensation of a provider on a capitation basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than:

- The time period specified in the provider contract between the provider and the CCN, or if a time period is not specified in the contract:
    - The tenth (10th) day of the calendar month if the payment is to be made by a contractor, or

- If the CCN is required to compensate the provider directly, within five (5) calendar days after receipt of the capitated payment and supporting member roster information from DHH.

17.5.1.5. The CCN shall not deny provider claims on the basis of untimely filing in situations regarding coordination of services or subrogation, in which case the provider is pursuing payment from a third party. In situations of third party benefits, the timeframes for filing a claim shall begin on the date that the third party completes resolution of the claim.

17.5.1.6. The CCN shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or CHIP program pursuant to Section 1128 or 1156 of the Social Security Act or is otherwise not in good standing with DHH.

17.5.2. Claims Dispute Management

17.5.2.1. The CCN shall have an internal claims dispute procedure that shall be submitted to DHH within thirty (30) days of the date the Contract is signed by the CCN, which will be reviewed and approved by DHH.

17.5.2.2. The CCN shall contract with independent reviewers to review disputed claims.

17.5.2.3. The CCN shall systematically capture the status and resolution of all claim disputes as well as all associated documentation.

17.5.3. Claims Payment Accuracy Report

17.5.3.1. On a monthly basis, the CCN shall submit a claims payment accuracy percentage report to DHH. The report shall be based on an audit conducted by the CCN. The audit shall be conducted by an entity or staff independent of claims management as specified in this Section of the RFP, and shall utilize a randomly selected sample of all processed and paid claims upon initial submission in each month. A minimum sample consisting of two hundred (200) to two hundred-fifty (250) claims per year, based on financial stratification, shall be selected from the entire population of electronic and paper claims processed or paid upon initial submission.

17.5.3.2. The minimum attributes to be tested for each claim selected shall include:

- Claim data correctly entered into the claims processing system;
- Claim is associated with the correct provider;
- Proper authorization was obtained for the service;
- Member eligibility at processing date correctly applied;
- Allowed payment amount agrees with contracted rate;
- Duplicate payment of the same claim has not occurred;
- Denial reason applied appropriately;
- Co-payment application considered and applied, if applicable;
- Effect of modifier codes correctly applied; and

- Proper coding.

17.5.3.3. The results of testing at a minimum should be documented to include:

- Results for each attribute tested for each claim selected;
- Amount of overpayment or underpayment for each claim processed or paid in error;
- Explanation of the erroneous processing for each claim processed or paid in error;
- Determination if the error is the result of a keying error or the result of error in the configuration or table maintenance of the claims processing system; and
- Claims processed or paid in error have been corrected.

17.5.3.4. If the CCN contracted for the provision of any covered services, and the CCN's contractor is responsible for processing claims, then the CCN shall submit a claims payment accuracy percentage report for the claims processed by the contractor.

17.5.4. Encounter Data

17.5.4.1. The CCN's system shall be able to transmit to and receive encounter data from the DHH FI's system as required for the appropriate submission of encounter data.

17.5.4.2. Within sixty (60) days of operation in the applicable geographic service area, the CCN's system shall be ready to submit encounter data to the FI in a provider-to-payer-to-payer COB format. The CCN must incur all costs associated with certifying HIPAA transactions readiness through a third-party, EDIFECS, prior to submitting encounter data to the FI. Data elements and reporting requirements are provided in the ***CCN-P Systems Companion Guide.***

- All encounters shall be submitted electronically in the standard HIPAA transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-payer COB Transaction formats (P - Professional, and I - Institutional). Compliance with all applicable HIPAA, federal and state mandates, both current and future is required.

17.5.4.3. The CCN shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided.

17.5.4.4. 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.

17.5.4.5. In addition to CPT, ICD-9-CM and other national coding standards, the use of applicable HCPCS Level II and Category II CPT codes are mandatory, aiding both the CCN and DHH to evaluate performance measures.

17.5.4.6. The CCN shall have the capability to convert all information that enters its claims system via hard copy paper claims to electronic encounter data, to be submitted in the appropriate HIPAA compliant formats to DHH's FI.

17.5.4.7. The FI encounter process shall utilize a DHH-approved version of the claims processing system (edits and adjudication) to identify valid and invalid encounter records from a batch submission by the CCN. Any submission which contains fatal errors that prevent processing, or that does not satisfy defined threshold error rates, will be rejected and returned to the CCN for immediate correction.

17.5.4.8. DHH and its FI shall determine which claims processing edits are appropriate for encounters and shall set encounter edits to "pay" or "deny". Encounter denial codes shall be deemed "repairable" or "non-repairable". An example of a repairable encounter is "provider invalid for date of service". An example of a non-repairable encounter is "exact duplicate". The CCN is required to be familiar with the FI exception codes and dispositions for the purpose of repairing denied encounters.

17.5.4.9. As specified in the ***CCN-P Systems Companion Guide***, denials for the following reasons will be of particular interest to DHH:

- Denied for Medical Necessity including lack of documentation to support necessity;
- Member has other insurance that must be billed first;
- Prior authorization not on file;
- Claim submitted after filing deadline; and
- Service not covered by CCN.

17.5.4.10. The CCN shall utilize DHH provider billing manuals and become familiar with the claims data elements that must be included in encounters. The CCN shall retain all required data elements in claims history for the purpose of creating encounters that are compatible with DHH and its FI's billing requirements.

17.5.4.11. Due to the need for timely data and to maintain integrity of processing sequence, the CCN shall address any issues that prevent processing of an encounter; acceptable standards shall be ninety percent (90%) of reported repairable errors are addressed within thirty (30) calendar

days and ninety-nine percent (99%) of reported repairable errors within sixty (60) calendar days or within a negotiated timeframe approved by DHH. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan may result in monetary penalties.

17.5.4.12. For encounter data submissions, the CCN shall submit ninety-five (95%) of its encounter data at least monthly due no later than the twenty-fifth (25th) calendar day of the month following the month in which they were processed and approved/paid, including encounters reflecting a zero dollar amount ($0.00) and encounters in which the CCN has a capitation arrangement with a provider. The CCN CEO or CFO shall attest to the truthfulness, accuracy, and completeness of all encounter data submitted.

17.5.4.13. The CCN shall ensure that all encounter data from a contractor is incorporated into a single file from the CCN. The CCN shall not submit separate encounter files from CCN contractors.

17.5.4.14. The CCN shall ensure that files contain settled claims and claim adjustments or voids, including but not limited to, adjustments necessitated by payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the CCN has a capitation arrangement.

17.5.4.15. The CCN shall ensure the level of detail associated with encounters from providers with whom the CCN has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the CCN received and settled a fee-for-service claim.

17.5.4.16. The CCN shall adhere to federal and/or department payment rules in the definition and treatment of certain data elements, such as units of service that are a standard field in the encounter data submissions and will be treated similarly by DHH across all CCNs.

17.5.4.17. Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the CCNs applicable reimbursement methodology for that service.

17.5.5. Claims Summary Report

17.5.5.1. The CCN must submit quarterly, Claims Summary Reports to DHH by GSA and by claim type.

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18.0 REPORTING

The CCN shall comply with all the reporting requirements established by this Contract. As per 42 CFR §438.242(a)(b)(1)(2) and (3), the CCN shall maintain a health information system that collects, analyzes, integrates and reports data that complies with DHH and federal reporting requirements. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and member disenrollment for reasons other than loss of Medicaid eligibility. The CCN shall collect data on member and provider characteristics and on services furnished to members.

The CCN shall create reports or files (known as Deliverables) using the electronic formats, instructions, and timeframes as specified by DHH and at no cost to DHH. Any changes to the formats must be approved by DHH prior to implementation.

The CCN shall provide DHH with a sample of all reports within forty-five (45) calendar days following the date the Contract is signed.

In the event that there are no instances to report, the CCN shall submit a report so stating.

As required by 42 CFR §438.604(a) and (b), and 42 CFR §438.606, 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, encounter data, and other information as specified within the Contract and this RFP. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The CCN must submit the certification concurrently with the certified data and documents. DHH will identify specific data that requires certification.

The data shall be certified by one of the following:

- CCN's Chief Executive Officer (CEO);
- CCN's Chief Financial Officer (CFO); or
- An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.

18.1. *Ad Hoc* Reports

The 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.

18.2. Ownership Disclosure

Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR §455.100-455.104). Form CMS 1513, Ownership and Control Interest Statement, is to be submitted to DHH with the proposal; then

resubmitted 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.

18.3. Information Related to Business Transactions

18.3.1. The CCN shall furnish to DHH or to the HHS, information related to significant business transactions as set forth in 42 CFR §455.105. Failure to comply with this requirement may result in termination of this Contract.

18.3.2. The CCN shall submit, within thirty-five (35) days of a request made by DHH, full and complete information about:

18.3.2.1. The ownership of any subcontractor with whom the CCN has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of this request; and

18.3.2.2. Any significant business transactions between the CCN and any wholly owned supplier, or between the CCN and any subcontractor, during the five (5) year period ending on the date of this request.

18.3.3. For the purpose of this Contract, "significant business transactions" means any business transaction or series of transactions during any state fiscal year that exceed the $25,000 or five (5%) percent of the CCN's total operating expenses whichever is greater.

18.4. Encounter Data

18.4.1. The CCN shall comply with the required format provided by DHH. Encounter data includes claims paid by the CCN for services delivered to enrollees through the CCN during a specified reporting period. DHH collects and uses this data for many reasons such as: federal reporting, rate setting, risk adjustment, service verification, managed care quality improvement program, utilization patterns and access to care, DHH hospital rate setting and research studies.

18.4.2. DHH may change the Encounter Data Transaction requirements with one hundred-fifty (150) calendar days' written notice to the CCN. The CCN shall, upon notice from DHH, provide notice of changes to subcontractors.

18.5. Information on Persons Convicted of Crimes

The CCN shall furnish DHH information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR §455.106. Failure to comply with this requirement may lead to termination of this Contract.

18.6. Errors

18.6.1. The 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:

18.6.1.1. For encounters - In accordance with the timeframes specified in the Administrative Actions, Monetary Penalties and Sanctions Section of this RFP.

18.6.1.2. 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.

18.6.2. Failure of the CCN to respond within the above specified timeframes may result in a loss of any money due the CCN and the assessment of liquidated damages as provided in Administration Actions, Monetary Penalties and Sanctions Section of this RFP.

18.7. Report Submission Timeframes

18.7.1. 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.

18.7.2. Unless otherwise specified, deadlines for submitting files and reports are as follows:

18.7.2.1. Daily reports and files shall be submitted within one (1) business day following the due date;

18.7.2.2. Weekly reports and files shall be submitted on the Wednesday following the reporting week;

18.7.2.3. Monthly reports and files shall be submitted within fifteen (15) calendar days of the end of each month;

18.7.2.4. Quarterly reports and files shall be submitted by April 30, July 30, October 30, and January 30, for the quarter immediately preceding the due date;

18.7.2.5. Annual reports and files shall be submitted within thirty (30) calendar days following the twelfth (12th) month; and

18.7.2.6. Ad Hoc reports shall be submitted within three (3) business days from the agreed upon date of delivery.

18.8. Report Submissions Chart

The report submission chart contains a summarized list of reports or files to be submitted by CCNs, DHH and the Enrollment Broker. The established format and/or layout requirements for each report or file are located in the Systems Companion Guide, Quality Companion Guide, Appendices of this RFP, or are in development (TBD). Proposers are encouraged to submit samples of existing reports for consideration by DHH for those reports identified in the report chart as TBD.

Submitter	Report or File Name	Frequency	Format Location	Receiver
CCN	Organizational Chart	Annually	N/A	DHH – Coordinated Care Section
CCN	Functional Organizational Chart	Annually	N/A	DHH – Coordinated Care Section
CCN	Network Provider and Subcontractor Registry	At Readiness Review and Monthly thereafter	Appendix FF	DHH – Coordinated Care Section
DHH – Coordinated Care Section	Readiness Review Report	As Appropriate	TBD	CCN
CCN	Patient-Center Medical Home (PCMH) A. PCMH Implementation Plan B. B. NCQA PCP-PCMH™ recognition report	During Readiness Review and Annually thereafter	TBD	DHH – Coordinated Care Section
DHH – FI	New Enrollee File	Daily	Systems Companion Guide TBD	EB
CCN	Provider Directory	Template due during Readiness Review	TBD	EB
EB	Provider Directory	Weekly	TBD	DHH
EB	Member Linkage File	Daily	Systems Companion Guide TBD	CCN

Submitter	Report or File Name	Frequency	Format Location	Receiver
EB	Member Linkage File	Daily	Systems Companion Guide TBD	DHH – FI
CCN	PCP Linkage File	Quarterly	Systems Companion Guide TBD	DHH – FI
CCN	Member Services A. Unsuccessful new member contacts B. 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
CCN	Referral Policies	During Readiness Review, Annually thereafter, and prior to any revisions	TBD	DHH – Coordinated Care Section
CCN	Non-Medicaid Enrolled Providers	Monthly	TBD	DHH – FI
EB	Member Disenrollment File	Daily	Systems Companion Guide TBD	DHH – FI
CCN	CCN Disenrollment Report	Quarterly	Appendix T	DHH - Coordinated Care Section
DHH – FI	CCN PMPM Reconciliation File	Monthly	Systems Companion Guide TBD	CCN
CCN	Abortion Consents	As appropriate	Appendix N	DHH
CCN	Hysterectomy Consent Form	As appropriate	Appendix L	DHH

Submitter	Report or File Name	Frequency	Format Location	Receiver
CCN	Sterilization Consent Form	As appropriate	Appendix M	DHH
CCN	EPSDT Report (CMS 416)	Quarterly and Annually, due March 31 (6 months after the end of the FFY)	Appendix HH	Quarterly DHH – Program Operations Section Annual - FI
CCN	Medical Record Review	Within 30 days from the date the Contract is signed, and Annually thereafter	TBD	DHH – Coordinated Care Section
CCN	Service Area Review of Appointment Availability /Twenty-four (24) hour Access and Availability Survey	Annually	Instrument and Survey Results	DHH – Coordinated Care Section
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	TBD	DHH – Coordinated Care Section
CCN	Fraud and Abuse Activity Report	Quarterly with an Annual Summary	TBD	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
CCN	Model Attestation Letter	Attachment to all Reports	Appendix II	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

Submitter	Report or File Name	Frequency	Format Location	Receiver
CCN	Emergency Management Plan	During readiness review, 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	During readiness review and Annually thereafter	TBD	DHH – Coordinated Care Section
CCN	Grievance, Appeal and Fair Hearing Log Report	Monthly, and Quarterly Summary	Appendix CC	DHH – Coordinated Care Section
CCN	Grievance, Appeal and Fair Hearing Log - Redacted	Monthly, and Quarterly Summary	Appendix CC	DHH – Coordinated Care Section
CCN	Marketing Activities A. Marketing Plan B. Updates C. Annual Review	A. Due at Readiness Review B. Monthly C. Annually	Appendix BB	DHH – Coordinated Care Section
CCN	Third Party Liability Collections	Annually	Systems Companion Guide TBD	DHH
CCN	Claims Payment Accuracy Report	Monthly	Systems Companion Guide TBD	DHH – FI
CCN	Claims Summary Report	Quarterly	TBD	DHH – Coordinated Care Section
CCN	Claims Processing Interest Payments	Quarterly	TBD	DHH- Coordinated Care Section

Submitter	Report or File Name	Frequency	Format Location	Receiver
CCN	Annual Medical Loss Ratio Report	Beginning second CY of implementation Due June 1 for previous CY	TBD	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	Encounter Submission File	Weekly	Systems Companion Guide	DHH – FI
DHH – FI	Encounter Claims Summary File	Weekly	Systems Companion Guide	CCN
DHH – FI	Encounter Edit Disposition Summary File	Weekly	Systems Companion Guide	CCN
DHH – FI	Edit Code Detail File	Weekly	Systems Companion Guide	CCN
CCN	Denied Claims Report	Monthly	Systems Companion Guide	DHH – Coordinated Care Section
CCN	FQHC/RHC Encounter File	Monthly	Systems Companion Guide TBD	DHH – Program Operations

Submitter	Report or File Name	Frequency	Format Location	Receiver
CCN	Quality Assurance (QA) A. QAPI Program description and QAPI Plan B. Impact and effectiveness of QAPI program evaluation 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	During readiness review, and Annually thereafter A. 30 days from the date of the Contract and Annually thereafter B. Annually C. Within 3 months of execution of 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	Quality Companion Guide	DHH – Coordinated Care Section
CCN	System Refresh Plan	Annually	Systems Companion Guide TBD	DHH - Coordinated Care Section
CCN	Back-up File List	Quarterly	Systems Companion Guide TBD	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 TBD	CCN
CCN	Case Management Reports	Quarterly with an Annual Summary	TBD	DHH – Coordinated Care Section

Submitter	Report or File Name	Frequency	Format Location	Receiver
CCN	Prior Authorization and Pre-Certification Summary	Annually	Systems Companion Guide TBD	DHH – Coordinated Care Section
CCN	SAS 70 Report	Annually	N/A	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

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19.0 CONTRACT COMPLIANCE & MONITORING

The DHH/BHSF/Medicaid Coordinated Care Section will be responsible for the primary oversight of the Contract, including Medicaid policy decision making and Contract interpretation. As appropriate, DHH will provide clarification of CCN requirements and Medicaid policy, regulations and procedures and will schedule meetings as necessary with the CCN.

19.1. Contact Personnel

19.1.1. 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.

19.1.2. Contract Monitor

All work performed by the CCN will be monitored by the Contract Monitor:

To Be Named
Department of Health and Hospitals
Bureau of Health Services Financing
Medicaid Coordinated Care Section
628 North 4th St.
Baton Rouge, LA 70821
Phone:
E-mail:

19.2. Notices

Any notice given to a party under the Contract is deemed effective, if addressed to the party as addressed below, upon: (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by facsimile if a copy of the notice is sent by another means specified in this Section; (iii) the third Business Day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iv) the next Business Day after being sent by a nationally recognized overnight express courier with a reliable tracking system.

DHH
Name: TBD
Coordinated Care Section
628 North 4th St.

Baton Rouge, LA 70821

Contractor
Name TBD
Address TBD

Either party may change its address for notification purposes by providing written notice stating the change, effective date of change and setting forth the new address at least 10 days prior to the effective date of the change of address. If different representatives are designated after execution of the Contract, notice of the new representative will be given in writing to the other party and attached to originals of the Contract.

Whenever DHH is required by the terms of this RFP to provide written notice to the CCN, such notice will be signed by the Medicaid Director or his/her designee

19.3. Notification of CCN 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 under this Contract. The CCN will submit written requests to DHH for additional clarification, interpretation or other information. 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 Contract.

19.4. Required Submissions

Within thirty (30) calendar days from the date the Contract is signed by the CCN, the CCN shall submit documents as specified in this RFP. DHH shall have the right to approve, disapprove or require modification of these documents and any procedures, policies and materials related to the CCN's responsibilities under the terms of the Contract. Refer to Appendix JJ, **Transition Requirements** for a listing of submission requirements.

19.5. Readiness Review Prior to Operations Start Date

DHH will assess the performance of the selected CCNs prior to and after the January 2012 begin date for operations. DHH will complete readiness reviews of CCNs prior to implementation. This includes evaluation of all CCNs' program components including IT, administrative services and medical management. Each readiness review will be performed on site at the CCN's Louisiana administrative offices. Refer to Appendix JJ, **Transition Period Requirements**.

19.6. 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.

19.1.3. 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.

19.1.4. 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 may 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, utilization and financial records, review of the management systems and procedures developed under this Contract and any other areas or materials relevant or pertaining to this Contract.

19.1.5. The CCN shall provide access to documentation, medical records, premises, and staff as deemed necessary by DHH.

19.1.6. 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.

19.7. CCN On-Site Reviews

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

19.1.7. Administrative capabilities
19.1.8. Governing body
19.1.9. Subcontracts
19.1.10. Provider network capacity and services
19.1.11. Provider Complaints
19.1.12. Member services
19.1.13. PCP assignments and changes
19.1.14. Enrollee grievances and appeals
19.1.15. Health education and promotion
19.1.16. Quality improvement
19.1.17. Utilization review
19.1.18. Data reporting
19.1.19. Coordination of care
19.1.20. Claims processing
19.1.21. Fraud and abuse

19.8. Monitoring Reports

DHH will require CCNs to submit monthly, quarterly, and annual reports that will allow DHH to assess the CCN's performance.

19.9. Corrective Action

When DHH establishes that a CCN is out of compliance with any of the above monitored activities, the CCN will be required to provide corrective action plans to ensure that the goals of the program will be met. DHH may levy penalties commensurate with the offense at its discretion.

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20.0 ADMINISTRATIVE ACTIONS, MONETARY PENALTIES, & SANCTIONS

20.1. Administrative Actions

20.1.1. 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:

20.1.1.1. A warning through written notice or consultation;

20.1.1.2. 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;

20.1.1.3. Review of prior authorization implementation processes;

20.1.1.4. Referral to the Louisiana Department of Insurance for investigation;

20.1.1.5. Referral for review by appropriate professional organizations;

20.1.1.6. Referral to the Office of the Attorney General for fraud investigation; and/or

20.1.1.7. Require submission of a corrective action plan.

20.2. Monetary Penalties

20.2.1. 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.

20.2.2. The decision to impose monetary penalties shall include consideration of the following factors:

20.2.2.1. The duration of the violation;

20.2.2.2. Whether the violation (or one that is substantially similar) has previously occurred;

20.2.2.3. The CCN's history of compliance;

20.2.2.4. The severity of the violation and whether it imposes an immediate threat to the health or safety of the Medicaid members; and

20.2.2.5. The "good faith" exercised by the CCN in attempting to stay in compliance.

20.2.3. For purposes of this section, violations including individual, unrelated enrollees shall not be considered as 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 95 days prior to the Operational Start Date. One thousand ($1,000.00) per calendar day for each day the directory is late, inaccurate or incomplete.
System Readiness Review • Disaster Recovery Plan • Business Continuity Plan • Systems Quality Assurance Plan	CCN must submit to DHH or the Readiness Review Contractor the subject plans no later than 120 days prior to Operational Start Date. One thousand ($1,000.00) per calendar day for each day a deliverable is late, inaccurate, or incomplete.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**SANCTION**
Encounter Data	Ten thousand dollars ($10,000.00) per calendar day for each day after the due date that the monthly encounter data has not been received in the format and per specifications outlined in the RFP. Ten thousand dollars ($10,000.00) per calendar day for each day encounter data is received after the due date, for failure to correct and resubmit encounter data that was originally returned to the CCN for correction because submission data was in excess of the five (5) percent error rate threshold, until acceptance of the data by the fiscal intermediary. Ten thousand dollars ($10,000.00) per return by the fiscal intermediary of re-submission of encounter data that was returned to the CCN, as submission data was in excess of the five (5) percent error rate threshold, for correction and was rejected for the second time. Ten thousand dollars ($10,000.00) per occurrence of medical record review by DHH or its designee where the CCN or its provider(s) denotes provision of services which were not submitted in the encounter data regardless of whether or not the provider was paid for the service that was documented. Penalties specified above shall not apply for encounter data for the first three months after direct services to CCN members have begun to permit time for development and implementation of a system for exchanging data and training of staff and health care providers.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**SANCTION**
Prompt Pay • Ninety percent (90%) of all clean claims must be paid within fifteen (15) business days of the date of receipt. • Ninety-nine percent (99%) of all clean claims must be paid within thirty (30) calendar days of the date of receipt. • The CCN shall pay providers interest at 12% per annum, calculated daily for the full period in which the clean claim remains unadjudicated beyond the 30-day claims processing deadline. Interest owed the provider must be paid the same date that the claim is adjudicated.	Five thousand dollars ($5,000.00) for the first quarter that a CCN's claims performance percentages by claim type and by GSA fall below the performance standard. Twenty-five thousand dollars ($25,000.00) per quarter for each additional quarter that the claims performance percentages by claim type, by CCN and GSA fall below the performance standards. One thousand dollars ($1,000.00) per claim if the CCN fails to timely pay interest.
Claims Summary Report	One thousand dollars ($1,000.00) per calendar day the report 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*.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**SANCTION**
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 or incorrect.
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 (minimum of (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 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	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

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**SANCTION**
• Maintain abandoned rate of calls of not more than 5%	which the CCNs average hold time exceeds the maximum acceptable hold time per CCN.
Administrative Service	Failure which results in actual harm to a member, places a member at risk of imminent harm, or materially affects DHH's ability to administer the Program. Five thousand dollars ($5,000.00) per calendar day for each incident of non-compliance per CCN per Geographic Service Area (GSA).
Provider Demographics	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.
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.
Provider Call Center • Answer 95% of calls within 30 seconds • Maintain an average hold time of 3 minutes or less • Maintain abandoned rate of	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 thirty (30) second time increment, or portion thereof, by which the CCNs average hold time

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**SANCTION**
calls of not more than 5%	exceeds the maximum acceptable hold time per CCN.
Covered Services	Failure to provide a CCN covered service that is not otherwise associated with a performance standard and such failure results in actual harm to a member or places a member at risk of imminent harm. Seventy-five hundred dollars ($7,500.00) per calendar day for each incident of non-compliance per CCN per GSA.
Management Information System	In the event of a declared major failure or disaster, the CCN's core eligibility, enrollment, and claims processing system shall be back on line within seventy-two (72) hours of the failure or disaster's occurrence. Five thousand dollars ($5,000.00) per calendar day of non-compliance per CCN per GSA.
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).
Transfer of Data	The CCN must transfer all data regarding the provision of covered services to members, to DHH or a new CCN, at the sole discretion of DHH and as directed by DHH. Ten thousand dollars ($10,000.00) per calendar day that the data is late, inaccurate or incomplete.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLES	**SANCTION**
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.	Two thousand dollars ($2,000.00) per calendar day for each business day that a report is late or incorrect.

20.2.4. DHH shall utilize the following guidelines to determine whether a report is correct and complete:

20.2.4.1. The report must contain 100% of the CCN's data; and

20.2.4.2. 99% of the required items for the report must be completed; and

20.2.4.3. 99.5% of the data for the report must be accurate as determined by edit specifications/review guidelines set forth by DHH.

20.3. Other Reporting and/or Deliverable Requirements

20.3.1. 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. .

20.3.2. 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

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
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

20.4. Employment of Key and Licensed Personnel

20.4.1. 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;

20.4.2. 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.

20.4.3. 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.

20.5. Excessive Reversals on Appeal

Twenty-five thousand dollars ($25,000.00) for exceeding ten percent (10%) member appeals over a twelve month period (January-December) which have been overturned in a State Fair Hearing; or for each occurrence in which the CCN does not provide the medical services or requirements set forth in a final appeal outcome.

20.6. Marketing and Member Education Violations

20.6.1. 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.

20.6.2. Unfair, deceptive, or prohibited marketing practices shall include, but is not limited to:

20.6.2.1. Failure to secure written approval before distributing marketing or member education materials;

20.6.2.2. Engaging in, encouraging or facilitating prohibited marketing by a provider;

20.6.2.3. Directly marketing to enrollees or potential enrollees;

20.6.2.4. Failure to meet time requirements for communication with new members (distribution of welcome packets, welcome calls);

20.6.2.5. Failure to provide interpretation services or make materials available in required languages.

20.6.2.6. Engaging in any of the prohibited marketing and member education practices detailed in this RFP;

20.6.2.7. 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;

20.6.2.8. Representation that a CCN or network provider offers any service, benefit, access to care, or choice which it does not have;

20.6.2.9. Representation that a CCN or health care provider has any status, certification, qualification, sponsorship, affiliation, or licensure which it does not have;

20.6.2.10. Failure to state a material fact if the failure deceives or tends to deceive;

20.6.2.11. 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, unless the benefit offered is medically necessary health care; and

20.6.2.12. Use of the Medicaid eligible's or another person's information which is confidential, privileged, or which cannot be disclosed to or obtained by the user without violating a state or federal confidentiality law, including:

- Medical records information, and
- Information which identifies the recipient or any member of his or her group as a recipient of any government sponsored or mandated health coverage program; and

20.6.2.13. 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.

20.7. 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.

20.7.1. DHH may require the CCN to recall the previously authorized marketing material(s);

20.7.2. DHH may suspend enrollment of new members to the CCN;

20.7.3. DHH may deduct the amount of capitation payment for members enrolled as a result of non-compliant marketing practices from the next monthly capitation payment made to the CCN and shall continue to deduct such payment until correction of the failure;

20.7.4. 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

20.7.5. DHH may prohibit future marketing activities by the CCN for an amount of time specified by DHH.

20.8. Cost Avoidance Requirements

Whenever DHH determines that the CCN is not actively engaged in cost avoidance the CCN shall be subject to sanctions in an amount not less than three (3) times the amount that could have been cost avoided.

20.9. 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.

20.10. Failure to Maintain an Adequate Network of Contract Providers

In the event that DHH determines that the CCN 1) failed to maintain an adequate network of mandatory contract provider types as specified in Section § 7 of this RFP, 2) did not comply with the requirement to make three documented attempts to contract with the provider, and 3) is required to pay for medically necessary services to a non-network provider, a monetary penalty of up to $10,000 per incident may be assessed.

20.11. Intermediate Sanctions

20.10.1 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—

20.11.1.1. 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;

20.11.1.2. Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Louisiana Medicaid CCN Program;

20.11.1.3. 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 Section § 11.12.2 or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future medical services.

20.11.1.4. Misrepresents or falsifies information that it furnishes to CMS or to DHH;

20.11.1.5. Misrepresents or falsifies information that it furnishes to a member, potential member, or a health care provider;

20.11.1.6. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210;

20.11.1.7. Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by DHH or that contain false or materially misleading information; or

20.11.1.8. Violates any of the other applicable requirements of Section 1903(m), 1905(t)(3) or 1932 of the Social Security Act and any implementing regulations.

20.11.2. 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 §§438.700-730 and may include any of the following:

20.11.2.1. Civil monetary penalties in the following specified amounts:

- A maximum of $25,000 for each determination of failure to provide services; misrepresentation or falsification of statements to members, potential members, or health care providers; failure to comply with physician incentive plan requirements; or marketing violations;

- A maximum of $100,000 for each determination of discrimination among members on the basis of their health status or need for services; or misrepresentation or falsification to CMS or DHH;

- A maximum of $15,000 for each member DHH determines was discriminated against based on the member's health status or need for services (subject to the $100,000 limit above);

- A maximum of $25,000 or double the amount of the excess charges (whichever is greater), for charging premiums or charges in excess of the amounts permitted under the Louisiana Medicaid CCN Program. DHH shall return the amount of overcharge to the affected member(s);

20.11.2.2. Appointment of temporary management for a CCN as provided in 42 CFR 438.706;

20.11.2.3. Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll;

20.11.2.4. Suspension of all new enrollments, including automatic assignment, after the effective date of the sanction;

20.11.2.5. 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.

20.11.2.6. Additional sanctions allowed under state statutes or regulations that address areas of noncompliance described above.

20.11.3. The following factors will be considered in determining sanction(s) to be imposed:

20.11.3.1. Seriousness of the offense(s);

20.11.3.2. Patient quality of care issues;

20.11.3.3. Failure to perform administrative functions;

20.11.3.4. Extent of violations; history of prior violations; prior imposition of sanctions;

20.11.3.5. Prior provision of provider education; provider willingness to obey program rules;

20.11.3.6. Whether a lesser sanction will be sufficient to remedy the problem; and

20.11.3.7. Actions taken or recommended by peer review groups or licensing boards.

20.12. Suspension of Enrollment

If DHH determines that the CCN is out of compliance with the Contract, DHH may instruct the Enrollment Broker to suspend the CCN's enrollment of new members under the Contract after notification by DHH. DHH, when exercising this option, will

notify the CCN in writing of its intent to suspend new enrollment prior to the beginning of the suspension period. The suspension period may be for any length of time specified by DHH. DHH will submit a Notice of Suspension of Enrollment no less than five (5) calendar days previous to initiation of the suspension. The Louisiana Medicaid Director may require the provider to correct any deficiencies which served as the basis for the suspension as a condition of reinstatement of enrollment activities.

20.13. Misconduct for Which Intermediate Sanctions May Be Imposed

20.13.1. DHH may impose sanctions against any CCN if the agency finds any of the following non-exclusive actions/occurrences:

20.13.1.1. The CCN has failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from DHH;

20.13.1.2. The CCN has been excluded from participation in Medicare because of fraudulent or abusive practices pursuant to Public Law 95-142;

20.13.1.3. 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;

20.13.1.4. 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 the federal Department of Health and Human Services;

20.13.1.5. 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;

20.13.1.6. The CCN has rebated or accepted a fee or portion of fee or charge for a patient referral;

20.13.1.7. The CCN has failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments;

20.13.1.8. The CCN has failed to keep or make available for inspection, audit or copying, such records regarding payments claimed for providing services;

20.13.1.9. The CCN has failed to furnish any information requested by DHH regarding payments for providing goods or services;

20.13.1.10. 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;

20.13.1.11. 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.

20.14. 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.

20.15. 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.

20.15.1. Substantial failure to provide required medically necessary items or services when the failure had adversely affected (or has substantial likelihood of adversely affecting) a member;

20.15.2. 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;

20.15.3. Misrepresentation or falsification of certain information; or

20.15.4. Failure to comply with the requirements for physician incentive plans as specified herein.

20.16. Sanction by CMS—Special Rules Regarding Denial of Payment

Payments provided under this Contract may be denied by CMS, in accordance with the requirements in 42 CFR 438.730.

20.17. Payment of Monetary Penalties

20.17.1. 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.

20.17.2. 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.

20.17.3. 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.

20.18. Corrective Action

20.18.1. DHH may require a corrective action plan, as referenced in Section § 20.1.1.7, 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.

20.18.2. 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.

20.19. 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.

20.20. Termination for Cause

20.20.1. 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.

20.20.2. 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.

20.20.3. The termination will be effective no less than thirty (30) calendar days from the date of the Notice of Intent to Terminate. The 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.

20.20.4. 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.

20.20.5. 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.

20.20.6. The decision by the DHH Undersecretary is the exclusive remedy and LA R.S. 49:950-999.25, the Administrative Procedure Act, does not apply. The Notice of Termination will state the effective date of termination.

20.20.7. DHH will notify the Medicaid members enrolled in the 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.

20.21. Termination Due to Serious Threat to Health of Members

DHH may terminate this Contract immediately if it is determined that actions by the 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.

20.22. Termination for CCN Insolvency, Bankruptcy, Instability of Funds

20.22.1. 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.

20.22.2. 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.

20.23. Termination for Ownership Violations

The CCN is subject to termination, unless the CCN can demonstrate changes of ownership or control, when:

20.23.1. A person with a direct or indirect ownership interest in the CCN:

20.23.1.1. 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;

20.23.1.2. Has had civil liquidated damages or assessment imposed under § 1128A of the Act; or

20.23.1.3. Has been excluded from participation in Medicare or any state health care program.

20.23.2. Any individual who has a direct or indirect ownership interest or any combination thereof of 5% or more, or who is an officer (if the CCN is organized as a corporation), or who is a partner (if it is organized as a partnership), or who is an agent or a managing employee, has one of the conditions specified in §§ 20.21.1.1 - 20.21.1.3 above.

20.23.3. 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.

20.24. Special Rules for Temporary Management

20.24.1. Temporary management may be imposed by DHH only if it finds that:

20.24.1.1. is continued egregious behavior by the CCN, including, but not limited to behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Social Security Act; or

20.24.1.2. There is substantial risk to members' health; or

20.24.1.3. The sanction is necessary to ensure the health of the CCN's members while improvements are made to remedy violations under 42 CFR 438.700 or until there is an orderly termination or reorganization of the CCN.

20.24.2. DHH shall impose temporary management if it finds that the CCN has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act. DHH shall also grant members the right to terminate enrollment without cause and shall notify the affected members of their right to terminate enrollment.

20.24.3. DHH will not delay imposition of temporary management to provide a hearing before imposing temporary management for the reasons specified in §§ 20.22.1.1 - 20.22.1.3 above.

20.24.4. The state will not terminate temporary management until it determines that the CCN can ensure that the sanctioned behavior will not recur.

20.24.5. DHH's election to appoint temporary management shall not act as an implied waiver of DHH's right to terminate the Contract, suspend enrollment, or to pursue any other remedy available to DHH under the Contract.

20.25. 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, Retainage, 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.

20.26. Provider Sanctions

Nothing contained herein shall prohibit DHH from imposing sanctions, including civil monetary penalties, license revocation and Medicaid termination, upon a health care provider for its violations of federal or state law, rule, or regulations.

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21.0 PROPOSAL AND EVALUATION

21.1. General Information

21.1.1. This section outlines the provisions which govern determination of compliance of each proposer's response to the RFP.

21.1.2. DHH shall determine, at its sole discretion, whether or not the requirements have been reasonably met.

21.1.3. Omissions of required information shall be grounds for rejection of the proposal by DHH.

21.2. Contact After Solicitation Deadline

After the date for receipt of proposals, no proposer-initiated contact relative to the solicitation will be allowed between the proposers and DHH until an award is made.

21.3. Rejection and Cancellation

21.3.1. Issuance of this solicitation does not constitute a commitment by DHH to award a contract or contracts The Department reserves the right to reject all proposals received in response to this solicitation.

21.3.2. In accordance with the provisions of R.S. 39:2182, in awarding contracts after August 15, 2010,any public entity is authorized to reject a proposal or bid from, or not award the contract to, a business in which any individual with an ownership interest of five percent or more, has been convicted of, or has entered a plea of guilty or *nolo contendere* to any state felony or equivalent federal felony crime committed in the solicitation or execution of a contract or bid awarded under the laws governing public contracts under the provisions of Chapter 10 of Title 38 of the Louisiana Revised Statutes of 1950, professional, personal, consulting, and social services procurement under the provisions of Chapter 16 of this Title, or the Louisiana Procurement Code under the provisions of Chapter 17 of this Title.

21.4. Code of Ethics

Proposers are responsible for determining that there will be no conflict or violation of the Ethics Code if their company is awarded a contract. The Louisiana Board of Ethics is they only entity which can officially rule on ethics issues.

21.5. Award Without Discussion

The Secretary of DHH reserves the right to make an award without presentations by proposers or further discussion of proposals received.

21.6. Assignments

Any assignment, pledge, joint venture, hypothecation of right or responsibility to any person, firm or corporation should be fully explained and detailed in the proposal.

Information as to the experience and qualifications of proposed subcontractors or joint ventures should be included in the proposal. In addition, written commitments from any subcontractors or joint ventures should be included as part of the proposal.

21.7. Proposer Prohibition

A proposer shall not submit multiple proposals 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.

21.8. Proposal Cost

The proposer assumes sole responsibility for any and all costs associated with the preparation and reproduction of any proposal submitted in response to this RFP, and shall not include this cost or any portion thereof in the proposed contract price.

21.9. Ownership of Proposal

All proposals become the property of DHH and will not be returned to the proposer. DHH retains the right to use any and all ideas or adaptations of ideas contained in any proposal received in response to this solicitation. Selection or rejection of the offer will not affect this right. Once a contract is awarded, all proposals will become subject to the Louisiana Public Records Act.

21.10. Procurement Library/Resources Available To Proposer

21.10.1. Electronic copies of material relevant to this RFP will be posted at the following web 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

21.10.2. Potential proposers may receive historic Medicaid de-identified claims data 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:

21.10.2.1. Submit the non-binding Letter of Intent to Propose to the RFP Coordinator;

21.10.2.2. Sign and submit the **CCN Data Use Agreement** (Appendix P) to the RFP Coordinator; and

21.10.2.3. Mail or deliver a computer flash drive or hard drive with a capacity of at least 16GB on which to load the historic claims data, along with the name and address to which DHH will mail the data via first class mail, return receipt

requested. Alternatively, provide the name of the person who will be picking up and signing for the data at the DHH Bienville Building, 628 North 4th Street , 6th Floor, Baton Rouge, LA . The storage drive and request for routing should be routed to the RFP Coordinator (See Section § 1.4.1).

21.10.2.4. The historical Medicaid claims data will be in SAS7BDAT format.

21.11. Proposal Submission

21.11.1. All proposals must be received by the due date and time indicated on the Schedule of Events. Proposals received after the due date and time will not be considered. It is the sole responsibility of each proposer to assure that its proposal is delivered at the specified location prior to the deadline. Proposals which, for any reason, are not so delivered will not be considered.

21.11.2. The Proposer shall submit one (1) original hard copy and ten (10) additional hard copies of each proposal. One electronic copy of the proposal, on a flash drive or CD(s) should be submitted as well. No facsimile or emailed proposals will be accepted.

21.11.3. 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

21.12. Proprietary and/or Confidential Information

21.12.1. The designation of certain information as trade secrets and/or privileged or confidential proprietary information is applicable to this proposal. Any proposal copyrighted or marked as confidential or proprietary in its entirety may be rejected without further consideration or recourse.

21.12.2. 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 proposal. Proposers should refer to the Louisiana Public Records Act for further clarification.

21.12.3. 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."

21.12.4. Further, to protect such data, each page containing such data shall be specifically identified and marked **"CONFIDENTIAL."**

21.12.5. 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.

21.12.6. 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."

21.12.7. Any proposal marked as confidential or proprietary in its entirety may be rejected without further consideration or recourse.

21.13. Waiver of Minor Proposal Errors

DHH may, at its sole discretion, waive minor errors or omissions in proposals/forms when those errors do not obscure the meaning of the content.

21.14. Proposal Clarifications

DHH reserves the right to request clarifications from proposers of any information in their proposals/forms, and may request such clarification as it deems necessary at any point in the proposal review process.

21.15. Interpretive Conventions

21.15.1. Whenever the terms “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.

21.15.2. Whenever the terms “can,” “may,” or “should” are used in this RFP in conjunction with a specification or performance requirement, the specification or performance requirement is a desirable, but not mandatory, requirement. Accordingly, a proposer’s failure to address or provide any items so referred to will not be the cause for rejection of the proposal, but will likely result in a less favorable evaluation.

21.16. Proposal Content

21.16.1. Proposals should include information that will assist the Department in determining the level of quality and timeliness that may be expected. DHH shall determine, at its sole discretion, whether or not the RFP provisions have been reasonably met. The proposal should describe the background and capabilities of the proposer, give details on how the services will be provided. Work samples may be included as part of the proposal.

21.16.2. Proposals should address how the proposer intends to assume complete responsibility for timely performance of all contractual responsibilities in accordance with federal and state laws, regulations, policies, and procedures.

21.16.3. Proposals should define proposer’s functional approach in providing services and identify the tasks necessary to meet the RFP requirements of the provision of services, as outlined in the RFP.

21.16.4. The Proposer may not submit the Proposer's own contract terms and conditions or other requirements in a response to this RFP.

21.17. Proposal Format

21.17.1. Each proposal should be economically prepared, with emphasis on completeness and clarity of content. A proposal, as well as any reference material presented, must be written in English and should be typed on standard 8 1/2" x 11" paper with recommended margins of one inch. It should be single spaced with text no smaller than 11-point font; pages may be single sided or double sided. All proposal pages should be numbered and identified with the Proposer’s name. Materials should be sequentially filed in three ring binders no larger than three inches in thickness.

21.17.2. The RFP Appendix KK **CCN-P Proposal Submission and Evaluation Requirements** 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.

21.17.3. All information included in a Proposal should be relevant to a specific requirement detailed in the **CCN-P Proposal Submission and Evaluation Requirements**. All information should be incorporated into a response to a specific requirement and clearly referenced. For each response the Proposer should include both the section and number of the requirement, the GSA (s) to which the response is applicable and the text of the requirement from the **CCN-P Proposal Submission and Evaluation Requirements**.

21.17.4. 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.

21.17.5. 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.

21.17.6. 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-P Proposal Submission and Evaluation Requirement***s, 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. `

21.17.7. .Attachments should only be provided as requested in the ***CCN-P Proposal Submission and Evaluation Requirements*** and should be clearly labeled, including the Section and number from the Requirements. Any information not meeting these criteria will be deemed extraneous and will in no way contribute to the evaluation process

21.18. Evaluation Criteria

The following criteria will be used to evaluate proposals:

21.18.1. All proposals will be reviewed and scored for each Section by a Proposal Review Team (PRT), comprised of three or more DHH employees.

21.18.2. Proposal Review Team members 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.

21.18.3. Evaluations of the financial statements will be conducted by a member of the DHH Fiscal Division.

21.18.4. Each Proposal Evaluation Team member shall evaluate each proposal against the evaluation criteria in this RFP, rather than against other proposals, and scoring will be done by consensus of the PRT assigned to each Section.

21.18.5. Proposals containing assumptions, lack of sufficient detail, poor organization, lack of proofreading and unnecessary use of self-promotional claims will be evaluated accordingly.

21.18.6. DHH reserves the right, at its sole discretion, to request Proposer clarification of a Proposal provision or to conduct clarification discussions with any or all Proposers. Any such clarification or discussion shall be limited to specific sections of the proposal identified by DHH. The subject Proposer shall put any resulting clarification in writing as may be required by DHH.

21.18.7. Scoring will be based on a possible total of 1900 points, and the three (3) proposals with the highest total scores in each GSA may be recommended for award.

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21.19. Evaluation Categories and Maximum Points

DHH will consider each of the factors in the table below in the evaluation of proposals. The maximum points that can be awarded for each of these categories by GSA (GSA "A"—Regions 1,9, GSA "B—Regions 2, 3, & 4, and GSA "C"—Regions 5, 6, 7, & 8) are detailed below. There will be a maximum of 1900 points available for each GSA.

CATEGORY	MAXIMUM POINTS POSSIBLE
Qualifications and Experience	345
Planned Approach to Project	100
Member Enrollment and Disenrollment	25
Chronic Care/Disease Management	100
Service Coordination	170
Provider Network	200
Utilization Management	80
EPSDT	25
Quality Management	125
Member Materials	50
Customer Service	100
Emergency Management Plan	25
Grievance and Appeals	25
Fraud and Abuse	25
Third Party Liability	25
Claims Management	80
Information Systems	200
Added Value to Louisiana	200
TOTAL	**1,900**

21.20. Announcement of Awards

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 1,500 points. DHH reserves the right not to award a Contract or award fewer than three (3) contracts.

21.21. Notice of Contract Awards

The notice of intended contract award shall be sent by carriers that require signature upon receipt, by fax with voice confirmation, or by email with reply confirmation to the winning proposers. No proposer shall infer or be construed to have any rights or interest to a contract with DHH until both the proposer and DHH have executed a valid contract and final approval is received from all necessary entities.

22.0 TURNOVER REQUIREMENTS

22.1. 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.

22.2. General Turnover Requirements

In the event the Contract is terminated for any reason, the CCN shall:

22.2.1. Comply with all terms and conditions stipulated in the Contract, including continuation of core benefits and services under the Contract, until the termination effective date;

22.2.2. Promptly supply all information necessary for the reimbursement of any outstanding claims; and

22.2.3. Comply with direction provided by DHH to assist in the orderly transition of equipment, services, software, leases, etc. to DHH or a third party designated by DHH.

22.3. Turnover Plan

22.3.1. In the event of written notification of termination of the Contract by either party, the 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.

22.3.2. If the Contract is not terminated by written notification as provided in 22.3.1 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.

22.3.3. 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.

22.4. 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.

22.5. 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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23.0 TERMS AND CONDITIONS

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 Section § 19.2 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.

There may be an extension for an additional 24 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.

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 Contract, not specifically mentioned in this section, including those in the DHH pro forma contract. Any provision of this Contract which is in conflict with federal statutes, regulations, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and federal policy. Such amendment of the 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 Contract.

23.1. Amendments

The Contract may be amended at any time as provided in this paragraph. The Contract may be amended whenever appropriate to comply with state and federal requirements or state budget reductions 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 by 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 of the CMS Regional Office prior to the amendment implementation.

23.2. 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:

23.2.1. Title 42 Code of Federal Regulations (CFR) Chapter IV, Subchapter C (Medical Assistance Programs);

23.2.2. All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. 7401, et seq.) and 20 USC §6082(2) of the Pro-Children Act of 1994, as amended (P.L. 103-227);

23.2.3. Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. 2000d) and regulations issued pursuant thereto, 45 CFR part 80; In accordance with Title VI of the Civil Rights Act of 1964 (42U.S.C. 2000d et seq.) and its implementing regulation at 45 CFR Part 80, the CCN must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Contract;

23.2.4. Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. 2000e) in regard to employees or applicants for employment;

23.2.5. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 CFR Part 84;

23.2.6. The Age Discrimination Act of 1975, as amended, 42 U.S.C 6101 et seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance;

23.2.7. The Omnibus Budget Reconciliation Act of 1981, as amended, P.L.E.97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance;

23.2.8. The Balanced Budget Act of 1997, as amended, P.L. 105-33 and the Balanced Budget Refinement Act of 1999, as amended, H.R. 3426;

23.2.9. Americans with Disabilities Act, as amended, 42 U.S.C. §12101 et seq., and regulations issued pursuant thereto;

23.2.10. Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusion of CCNs for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;

23.2.11. 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;

23.2.12. Title IX of the Education Amendments of 1972 regarding education programs and activities; and

23.2.13. Byrd Anti-Lobbying Amendment Contractors who apply or bid shall file the require certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in

connection with obtaining any federal award. Such disclosures are forwarded form tier to tier up to the recipient (45 CFR Part 3).

23.3. Assessment of Fees

The Contractor and DHH agree that 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.

23.4. Attorney's Fees

In the event DHH should prevail in any legal action arising out of the performance or non-performance of the Contract, the 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.

23.5. 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.

23.6. Confidentiality of Information

23.6.1. The CCN shall assure that medical records and any and all other health and enrollment information an 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 reported as confidential information to the extent confidential treatment is provided under 45 CFR Parts 160 and 164 and other state and federal laws, DHH policies or this Contract. 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.

23.6.2. 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.

23.7. Conflict of Interest

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 1932 (d)(3) of the Social Security Act

addressing 1932 State Plan Amendment and the default enrollment process under the State Plan Amendment option.

23.8. Contract Language Interpretation

The CCN and DHH agree that in the event of a disagreement regarding, arising out of, or related to, Contract language interpretation, DHH's interpretation of the Contract language in dispute shall control and govern..

23.9. Cooperation with Other Contractors

23.9.1. In the event that DHH has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder including but not limited to fiscal intermediary and enrollment broker services, the CCN 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.

23.9.2. The CCN's failure to cooperate and comply with this provision, shall be sufficient grounds for DCH to halt all payments due or owing to the CCN until it becomes compliant with this or any other contract provision. DHH's determination on the matter shall be conclusive and not subject to Appeal.

23.10. Copyrights

If any copyrightable material is developed in the course of or under this Contract, DHH shall have a royalty free, non-exclusive, and irrevocable right to reproduce, publish, or otherwise use the work for DHH purposes.

23.11. Corporation Requirements

If the CCN is a corporation, the following requirement must be met prior to execution of the Contract:

23.11.1. If a for-profit corporation whose stock is not publicly traded-the CCN must file a Disclosure of Ownership form with the Louisiana Secretary of State.

23.11.2. 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.

23.11.3. The CCN must provide written assurance to DHH from the 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.

23.12. Debarment/Suspension/Exclusion

23.12.1. 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 must screen all employees and

subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or all federal 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://exclusions.oig.hhs.gov/search.aspx ; the Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.jsp and/or the Excluded Parties List Serve (EPLS) www.EPLS.gov .

23.12.2. The 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 liquidated damages may be imposed against providers who employ or enter into provider contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR §1003.102(a)(2).

23.13. Effect of Termination on CCN's HIPAA Privacy Requirements

23.13.1. 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 agents of the CCN. The CCN shall not retain any copies of the Protected Health Information.

23.13.2. 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.

23.14. Emergency Management Plan

23.14.1. 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.

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

23.14.2.1. Educating members and providers regarding hurricane preparedness and evacuation planning;

23.14.2.2. Provide a CCN contact list (phone and email) for members/providers to contact to determine where healthcare services may be accessed/rendered;

23.14.2.3. Identification of members with special healthcare needs who require evacuation assistance and informing local officials of those identified;

23.14.2.4. MOUs with healthcare providers (especially hospitals and dialysis providers) in northern parishes for provision of services to evacuated members;

23.14.2.5. MOUs with healthcare facilities in northern parishes that would allow evacuated providers to render services within their facilities;

23.14.2.6. Registry of healthcare providers (MD, nurses, social workers, etc) who are willing to volunteer in state operated Special Needs shelters;

23.14.2.7. Use of EHR to provide healthcare providers access to member's health history and receive information of care provided during evacuation; and

23.14.2.8. Emergency contracting with out-of-state healthcare providers to provide healthcare services to evacuated members.

23.15. Employee Education about False Claims Recovery

If the 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.

23.16. Employment of Personnel

23.16.1. In all hiring or employment made possible by or resulting from this Contract, the CCN agrees that:

23.16.1.1. There shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, or national origin; and

23.16.1.2. Affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in

accordance with all state and federal laws applicable to employment of personnel.

23.16.2. This requirement shall apply to, but not be limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff, termination, rates of pay or other forms of compensation, and selection for training including apprenticeship. The 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.

23.17. Entire Contract

This Contract, together with the RFP and addenda issued thereto by DHH, the proposal submitted by the proposer in response to DHH's RFP, and any exhibits specifically incorporated herein by reference constitute the entire agreement between the parties with respect o the subject matter.

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 applicable Department issued guides. 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 policies and procedures in effect throughout the duration of the Contract period. The CCN shall comply with all applicable DHH provider manuals, rules and regulations. Where the provisions of the Contract differ from the requirements set forth in the handbooks and/or manuals, the Contract provisions shall control.

DHH, at its discretion, will issue correspondence to inform the CCN of changes in Medicaid 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.

23.18. 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.

23.19. Fraudulent Activity

23.19.1. 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:

23.19.1.1. The number of complaints of fraud and abuse made to the CCN that warrant preliminary investigation; and

23.19.1.2. 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
- the legal and administrative disposition of the case

23.19.2. The CCN shall adhere to the policy and process contained in this RFP for referral of cases and coordination with the DHH's Program Integrity Unit for fraud and abuse complaints regarding members and providers.

23.20. Governing Law and Place of Suit

It is mutually understood and agreed that this Contract shall be governed by the laws of the state of Louisiana except its conflict of laws provision both as to interpretation and performance. Any administrative proceeding, action at law, suit in equity, or judicial proceeding for the enforcement of this Contract or any provision thereof shall be instituted only in the 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.

23.21. HIPAA Business Associate

Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as agreed upon in the **HIPAA Business Associate Agreement**, Appendix C.

23.22. HIPAA 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.

23.23. Hold Harmless

23.23.1. The CCN shall indemnify, defend, protect, and hold harmless DHH and any of its officers, agents, and employees from:

23.23.1.1. Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies for the CCN in connection with the performance of this Contract;

23.23.1.2. Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by CCN, its agents, officers, employees, or subcontractors in the performance of this Contract;

23.23.1.3. Any claims for damages or losses resulting to any person or firm injured or damaged by the 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;

23.23.1.4. 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;

23.23.1.5. Any claims for damages, losses, or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of DHH in connection with the defense of claims for such injuries, losses, claims, or damages specified above; and

23.23.1.6. Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHH or their agents, officers or employees, through the intentional conduct, negligence or omission of the CCN, its agents, officers, employees or subcontractors.

23.23.2. In the event of circumstances not reasonably within the control of the 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 any subcontractor(s), will have any liability or obligation on account of reasonable delay in the provision or the arrangement of covered services. Notwithstanding, as long as this Contract remains in full force and effect, the CCN shall be liable for the core benefits and services required to be provided or arranged for in accordance with this Contract.

23.23.3. DHH will provide prompt notice of any claim against it that is subject to indemnification by 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.

23.24. Hold Harmless as to the CCN Members

23.24.1. 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.

23.24.2. The CCN further agrees that the CCN member shall not be held liable for payment for core benefits and services furnished under a provider contract, referral, or other arrangement, to the extent that those payments would be in excess of the amount that the member would owe if the 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 the CCN.

23.24.3. 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.

23.25. Homeland Security Considerations

23.25.1. 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.

23.25.2. 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.

23.25.3. 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.

23.26. Incorporation of Schedules/Appendices

All schedules/appendices referred to in this RFP are attached hereto, are expressly made a part hereof, and are incorporated as if fully set forth herein.

23.27. Independent Provider

It is expressly agreed that the 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.

23.28. Integration

This Contract and its component parts shall be construed to be the complete integration of all understandings between the parties hereto. The CCN also agrees to be bound by the Contract and any rules or regulations that may be promulgated. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or affect whatsoever unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a written amendment executed and approved by the parties.

23.29. Interest

Interest generated through investments made by the CCN under this Contract shall be the property of the CCN and shall be used at the CCN's discretion.

23.30. Interpretation Dispute Resolution Procedure

23.30.1. 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.

23.30.2. The CCN shall submit, within twenty-one (21) days of said interpretation, a written request disputing the interpretation directly to the Medicaid Director. The ability to dispute an interpretation does not apply to language in the Contract that is based on federal or state statute, regulation or case law.

23.30.3. The Medicaid Director shall reduce the decision to writing and provide a copy to the CCN. The written decision of the Medicaid Director shall be final of DHH. The Medicaid Director will render his 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.

23.30.4. 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.

23.31. 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.

23.32. 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.

23.33. National Provider Identifier (NPI)

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).

23.34. 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.

23.35. Non-Waiver of Breach

23.35.1. 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.

23.35.2. Waiver of any breach of any term or condition in this Contract shall not be deemed a waiver of any prior or subsequent breach. No term or condition of this Contract shall be held to be waived, modified, or deleted except by an instrument, in writing, signed by the parties hereto.

23.36. Offer of Gratuities

By signing this Contract, the 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.

23.37. Order of Precedence

In the event of any inconsistency or conflict among the document elements of this Contract, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

23.37.1. The body of the Contract with exhibits and attachments excluding the RFP and the contractors proposal;

23.37.2. This RFP and any addenda and appendices;

23.37.3. CCN-P Systems Companion Guide;

23.37.4. CCN Quality Companion Guide; and

23.37.5. The Proposal submitted by the CCN in response to this RFP.

23.38. Physician Incentive Plans

23.38.1. 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.

23.38.1.1. Assurances to CMS. Each organization will provide to DHH assurance satisfactory to the Secretary of HHS that the requirements of Sec. 422.208 are met.

23.39. Political Activity

None of the funds, materials, property, or services provided directly or indirectly under this Contract shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the "Hatch Act".

23.40. Prohibited Payments

Payment for the following shall not be made:

23.40.1. Organ transplants, unless the state plan has written standards meeting coverage guidelines specified;

23.40.2. Non-emergency services provided by or under the direction of an excluded individual;

23.40.3. Any amount expended for which funds may not used under the Assisted Suicide Funding Restriction Act of 1997;

23.40.4. Any amount expended for roads, bridges, stadiums, or any other item or service not covered under a state plan; and

23.40.5. Any amount expended for home health care services unless the organization provides the appropriate surety bond.

23.41. Rate Adjustments

The CCN and DHH both agree that the monthly capitation rates identified in this RFP shall be in effect during the period identified on the CCN Rate Schedule that will be posted on DHH's website. Rates may be adjusted during the Contract period based on DHH and actuarial analysis, subject to CMS review and approval.

The CCN and DHH both agree that the adjustments to the monthly capitation rate(s) required pursuant to this section shall occur only by written amendment to the Contract**.** Should either the CCN or DHH refuse to accept the revised monthly capitation rate, the provisions of the RFP for contract termination and turnover shall apply.

23.42. Record Retention for Awards to Recipients

Financial records, supporting documents, statistical records, and all other records pertinent to an award shall be retained for a period of six (6) years from the date of submission of the final expenditure report, or for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report. The only exceptions are the following:

23.42.1. If any litigation, claim , financial management review, or audit is started before the expiration of the six (6) year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken;

23.42.2. Records for real property and equipment acquired with federal funds shall be retained for six (6) years after final disposition;

23.42.3. When records are transferred to or maintained by DHH, the six (6) year retention requirement is not applicable to the recipient; and

23.42.4. Indirect cost rate proposals, cost allocations plans, etc., as specified in 45 CFR 74.53 (g).

23.43. Release of Records

The 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).

23.44. Reporting Changes

The CCN shall immediately notify DHH of any of the following:

- Change in business address, telephone number, facsimile number, and e-mail address;
- Change in corporate status or nature;
- Change in business location;
- Change in solvency;
- Change in corporate officers, executive employees, or corporate structure;
- Change in ownership, including but not limited to the new owner's legal name, business address, telephone number, facsimile number, and e-mail address;
- Change in incorporation status;
- Change in federal employee identification number or federal tax identification number; or
- Change in CCN litigation history, current litigation, audits and other government investigations both in Louisiana and in other states.

23.45. 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:

23.45.1. Be comparable to those imposed upon the DHH by 42 CFR Part 431, Subpart F (2005, as amended) and La R.S. 45:56;

23.45.2. 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;

23.45.3. 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;

23.45.4. Not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

23.45.5. Specify appropriate personnel actions to sanction violators.

23.46. Safety Precautions

DHH assumes no responsibility with respect to accidents, illnesses or claims arising out of any activity performed under this Contract. The 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.

23.47. Severability

If any provision of this Contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both DHH and 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.

23.48. 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.

23.49. Termination for Convenience

DHH may terminate this Contract for convenience and without cause upon sixty (60) calendar days written notice. DHH shall not be responsible to the CCN or any other party for any costs, expenses, or damages occasioned by said termination, i.e., this termination is without penalty.

23.50. Termination for Unavailability of Funds

In the event that federal and/or state funds to finance this Contract become unavailable after the effective date of this Contract, or prior to the anticipated Contract expiration date, DHH may terminate the Contract without penalty. This notification will be made in writing. Availability of funds shall be determined solely by DHH.

23.51. Time is of the Essence

Time is of the essence in this Contract. Any reference to “days” shall be deemed calendar days unless otherwise specifically stated.

23.52. Titles

All titles used herein are for the purpose of clarification and shall not be construed to infer a contractual construction of language.

23.53. Use of Data

DHH shall have unlimited rights to use, disclose, or duplicate, for any purpose, all information and data developed, derived, documented, or furnished by the CCN resulting from this Contract.

23.54. Waiver

The waiver by DHH of any breach of any provision contained in this Contract shall not be deemed to be a waiver of such provision on any subsequent breach of the same or any other provision contained in this Contract and shall not establish a course of performance between the parties contradictory to the terms hereof.

23.55. Warranty to Comply with State and Federal Regulations

The 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.

23.56. 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.

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GLOSSARY

Action - The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service, the failure to provide services in a timely manner (as defined by DHH), and the failure of the CCN to act within the timeframes for the resolution of grievances and appeals as described in 42 CFR §438.400(b); and in a rural area with only one CCN, the denial of a member's right to obtain services outside the provider network, as described in §438.52(b)(2)(ii).

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.

Acute Care Hospital - means a hospital that provides acute care services.

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.

Adjustments to Smooth Data – Adjustments made, by cost-neutral methods, across rate cells, to compensate for distortions in costs, utilization, or the number of eligibles.

Advance Directive – A written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.

Adverse Action – Any decision by the CCN-P 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-P entity and based upon the information provided, does not meet the CCN-P'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 - means the categories of individuals who meet the Medicaid eligibility factor of age, blindness, or a mental and/or physical disability.

Agent - An entity that contracts with DHH to perform administrative functions, including but not limited to fiscal intermediary activities, outreach, eligibility, and enrollment activities, systems and technical support, etc.

Ambulatory Care - Preventive, diagnostic and treatment services provided on an outpatient basis.

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-P 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 CCN, 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.

Bureau of Health Services Financing (BHSF) - The agency within the Louisiana Department of Health & Hospitals, Office of Management & Finance that has been designated as Louisiana's single state Medicaid agency to administer the Medicaid and CHIP programs.

Business Continuity Plan (BCP) - means a plan that provides for a quick and smooth restoration of MIS operations after a disruptive event. BCP includes business impact analysis, BCP development, testing, awareness, training, and maintenance. This is a day-to-day plan.

Business Day -Traditional workdays, including Monday, Tuesday, Wednesday, Thursday and Friday. State holidays are excluded and traditional work hours are 8:00 a.m. – 5:00 p.m. **,** unless the context clearly indicates otherwise.

CAHPS - The Consumer Assessment of Healthcare Providers and Systems is a standardized survey of members' experiences with ambulatory and facility-level care established by the Agency for Healthcare Research and Quality (AHRQ).

CCN Administrative Services - means the performance of services or functions, other than the direct delivery of core benefits and services, necessary for the management of the delivery of and payment for core benefits and services, including but not limited to network, utilization, clinical and/or quality management, service authorization, claims processing, management information systems operation, and reporting.

CCN-P Systems Companion Guide – A supplement to the Contract that outlines the formatting and reporting requirements concerning encounter data, interfaces between the FI and the CCN and enrollment broker and the CCN.

CMS 1500 - Universal claim form, required by CMS, to be used by non-institutional and institutional providers that do not use the UB-92.

CPT® - **Current Procedural Terminology**, current version, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. DHHS designated the CPT code set as the national coding standard for physician and other health care professional services and procedures under HIPAA.

Calendar Days - All seven (7) days of the week. Unless otherwise specified, the term "days" in the Contract refers to calendar days.

Capitation - A contractual agreement through which the CCN agrees to provide specified core health benefits and services to members for a fixed amount per month.

Capitation Payment - A payment, fixed in advance, that DHH makes to a CCN for each member covered under the Contract for the provision of core health benefits and services and assigned to the CCN. This payment is made regardless of whether the member receives core benefits and services during the period covered by the payment.

Capitation Rate - The fixed monthly amount that the CCN is prepaid by DHH for each member assigned to the CCN to ensure that core benefits and services under this Contract are provided.

Capitated Service - Any core benefit or service for which the CCN receives an actuarially sound capitation payment.

Care Coordination – Deliberate organization of patient care activities by a person or entity formally designated as primarily responsible for coordinating services furnished by providers involved in the member's care to facilitate care within the network with services provided by non-network providers to ensure appropriate delivery of 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."

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.

CHIP – Children's Health Insurance Program created in 1997 by Title XXI of the Social Security Act. Known in Louisiana as CHIP

***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 and enrollees on what factors to consider when choosing among them.

Chronic Condition - persistent or frequently recurring conditions of significant duration that may limit an individual's activities and require ongoing medical care to optimize the individual's quality of life.

Chronic Care Management Program (CCMP) – A program that provides care management and coordination of activities for individuals determined to be at risk for high medical costs.

Chronic Care Management - The concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care.

Claim – means 1) a bill for services 2) a line item of service or 3) all services for one recipient within a bill.

Clean Claim –. A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a state's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Cold Call Marketing – Any unsolicited personal contact with a Medicaid eligible individual by the CCN, its staff, its volunteers or its vendors/contractors with the purpose of influencing the Medicaid eligible individual to enroll in the CCN-P or either to not enroll in or disenroll from another CCN-P.

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– 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 contract.

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 (CCN) - An entity designed to improve performance and health outcomes through the creation of cost effective integrated healthcare delivery system that provides a continuum of evidence-based, quality-driven healthcare services for Medicaid eligibles.

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 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.

Coordination of Benefits (COB) - Refers to the activities involved in determining Medicaid benefits when a recipient has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.

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 - A schedule of health care benefits and services required to be provided by the CCN to Medicaid members as specified under the terms and conditions of this RFP and Contract and the Louisiana Medicaid State Plan.

Corrective Action Plan (CAP) – A plan developed by the 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.

Cost Avoidance - A method of paying claims in which the provider is not reimbursed until the provider has demonstrated that all available health insurance has been exhausted.

Cost Neutral – The mechanism used to smooth data, share risk, or adjust for risk that will recognize both higher and lower expected costs and is not intended to create a net aggregate gain or loss across all payments.

Covered Services - Those health care services/benefits to which an individual eligible for Medicaid or CHIP is entitled under the Louisiana Medicaid State Plan.

Cultural Competency - A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Members. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.

DHH Administrative Regions – The nine Louisiana geographic areas designated in state statute for administrative purposes. Each geographic area is comprised of specific parishes. For specific areas see:
http://www.dhh.louisiana.gov/offices/medialibrary/media-1/REG_MAP04.jpg

Deliverable - A document, manual or report submitted to DHH by the 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.

Direct Marketing/Cold Call - Any unsolicited personal contact with or solicitation of a Medicaid eligible in person, through direct mail advertising or telemarketing by an employee or agent of the CCN for the purpose of influencing an individual to enroll with the CCN.

Disease Management (DM) – see Chronic Care Management

Disenrollment - The removal of a member from participation in the CCN's 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 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-P.

Eligibility Determination - The process by which an individual may be determined eligible for the Medicaid or Medicaid-expansion CHIP program.

Eligible - An individual determined eligible for assistance in accordance with the Medicaid State Plan(s) under Title XIX (Medicaid) or Title XXI (CHIP) of the Social Security Act.

Emergency 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, and stabilize an emergency medical condition. Services defined as such under Section 1867 (e) of the Social Security Act ("anti-dumping provisions"). If

an emergency medical condition exists, the CCN is obligated to pay for the emergency service. Coverage of emergency services must not include any prior authorization requirements and the "prudent layperson" standard shall apply to both in-plan and out-of-plan coverage.

Encounter - A distinct set of health care services provided to a Medicaid member enrolled with a CCN on the dates that the services were delivered.

Encounter Data - Health care encounter data include: (i) All data captured during the course of a single health care encounter that specify the diagnoses, co-morbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the member receiving services during the encounter; (ii) The identification of the member receiving and the provider(s) delivering the health care services during the single encounter; and, (iii) A unique, *i.e.* unduplicated, identifier for the single encounter..

Encounter Data Adjustment - Adjustments to encounter data that are allowable under the Medicaid Management Information System (MMIS) for HCFA 1500, UB 92, KM-3 and NCPDP version 3.2 claim forms as specified in the ***CCN-P Systems Companion Guide***.

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 and 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.

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.

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.

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.

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 (FFY): October 1 through September 30; State Fiscal Year (SFY): July 1 through June 30.

Fraud – As relates to Medicaid Program Integrity, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law. Fraud may include deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received.

Full-Time Equivalent Position (FTE) – Refers to the equivalent of one (1) individual full-time employee who works forty (40) hours per week; or a full-time primary care provider shall be defined as a one delivering outpatient preventive and primary (routine, urgent and acute) care for twenty (20) hours or more per week (exclusive of travel time).

GEO Coding – Refers to the process in which implicit geographic data is converted into explicit or map-form images.

GEO Mapping - The process of finding associated geographic coordinates (often expressed as latitude and longitude) from other geographic data, such as street addresses, or zip codes (postal codes). With geographic coordinates the features can be mapped and entered into Geographic Information Systems, or the coordinates can be embedded into media.

Geographic Service Area (GSA) - All the parishes included in any DHH-defined service area, and within which the CCN has been selected and authorized by Contract to provide core benefits and services to Medicaid enrollees. The minimum geographic service area in which a CCN may provide core benefits and services shall be as follows: Region " A" consists of DHH Administrative Regions 1 and 9; Region "B" consists of DHH Administrative Regions 2, 3 and 4; and Region "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 that 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.

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 enrolled in CommunityCARE 2.0, by the provider (PCP or specialist) in the previous 12 months with whom the member had the most visits.

Health Information Technology for Economic and Clinical Health Act (HITECH Act) Title IV - The 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.

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.

Hospice – Services provided under fee-for-service as described in Louisiana Medicaid State Plan and 42 CFR §418, which are provided to terminally ill individuals, with a prognosis of six (6) months or less, who elect to receive hospice services provided by a certified hospice agency.

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. CCN-Ps 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, the 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 contract.

Incurred But Not Reported (IBNR) - Services rendered for which claim/encounter has not been received by the CCN.

Individual Practice - Independent primary care providers who work in their own private practices.

Individuals with Disabilities Education Act (IDEA) - A United States federal law that ensures services to children with disabilities throughout the United States. IDEA governs how states and public agencies provide early intervention, special education and related services to children with disabilities.

Information Systems (IS) - A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, *i.e*. structured data (which may include digitized audio and video)

and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.

Inpatient Facility - Hospital or clinic for treatment that requires at least one overnight stay.

Insolvency - A financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets, or as determined by the Louisiana Department of Insurance pursuant to Title 22 of the Louisiana Revised Statutes.

Institutionalized – A patient in a nursing facility; an in-patient in a medical institution or institution for mental disease, whereby payment is based on a level of care provided in a nursing facility; or receives home and community-based waiver services.

Investigational Procedure/Service – See Experimental Procedure/Service.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)/Joint Commission– An organization that operates accreditation programs to subscriber hospitals and other healthcare organizations.

Kick Payment - The method of reimbursing a CCN-P entity in the form of a separate one (1) time fixed payment for specific services in addition to the PMPM payment.

KIDMED - Louisiana's name for the screening component of the Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) program provided for Medicaid eligible children under the age of 21 as required by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89).

Laboratory and X-ray Services – Professional and technical laboratory and radiological services that are ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by state law or ordered by a physician but provided by referral laboratory; provided in an office or similar facility other than a hospital outpatient or clinic; and furnished by a laboratory that meets the requirements of 42 CFR §493.

LaCHIP – Refers to the Louisiana's Medicaid expansion CHIP (Title XXI) Program that provides health coverage to uninsured children under age 19, whose families have a net income up to 200 percent of the Federal Poverty Level (FPL); and whose income exceeds the Medicaid limit. Phase I includes children ages 6-18 with income from 100% up to and including 133% FPL; Phase II includes children with income from 134% up to and including 150% FPL; Phase III includes children with income from 151% FPL up to and including 200% FPL.

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 Children's Health Insurance Program (LaCHIP) – Louisiana's name for the Children's Health Insurance Plan created by Title XXI of the Social Security Act in 1997. Provides **h**ealth care coverage for uninsured children up to age 19 through a Medicaid expansion program for children at or below 200% FPL and a separate state CHIP program for the unborn prenatal option and for children with income from 200% up to and including 250% FPL.

Louisiana Department of Health and Hospitals (DHH) – The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Louisiana.

Louisiana's Health Insurance Premium Payment Program (LaHIPP) - Louisiana Medicaid program that pays for some or all of the health insurance premiums for an employee and their family if they have insurance available through their job and someone in the family is enrolled in Medicaid.

Louisiana Medicaid State Plan – The binding written agreement between DHH and CMS which describes how the Medicaid program is administered and determines the services for which DHH will receive federal financial participation.

Major Subcontract - means 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 $100,000 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, major subcontracts do not include contracts with any non-affiliates for any of the following, regardless of the value of the contract: utilities (*e.g.*, water, electricity, telephone, Internet), mail/shipping, office space, or computer hardware.

Major Subcontractor - Means any entity with a major subcontract with the 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.

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 enrollees**.**

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, the 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.

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 - 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 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.

Medicaid FFS Provider - An institution, facility, agency, person, corporation, partnership, or association that has signed a PE 50 agreement, been approved by DHH, and accepts payment in full for providing benefits, the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.

Medicaid Management Information System (MMIS) – Mechanized claims processing and information retrieval system which all states Medicaid programs are required to have and which must be approved by the Secretary of DHHS. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid Providers and Enrollees.

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 by the CCN from DHH used to pay medical claims from providers and approved quality improvement and IT costs.

Medical Loss Ratio Year—The calendar year for which Medical Loss Ratio is being reported.

Medical Record - A single complete record kept at the site of the member's treatment(s), which documents 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 Screening - An examination: (i.) provided on hospital property, and provided for that patient for whom it is requested or required, (ii.) Performed within the capabilities of the hospital, and provided for that patient for whom it is requested or required (iii.) The purpose of which is to determine if the patient has an Emergency Medical Condition, and (iv.) performed by a physician (M.D. or D.O.) and/or by a nurse practitioner, or physician assistant as permitted by state statutes and regulations and hospital bylaws.

Medical Vendor Administration (MVA) – Refers to the name for the budget unit specified in the Louisiana state budget that contains the administrative component of the Bureau of Health Services Financing (Louisiana's single state Medicaid agency).

Medically Necessary Services - Those 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 likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

The Medicaid Director, in consultation with the Medicaid 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 or CHIP eligible who enrolls in a CCN-P 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.

Methodology- 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 Committee for Quality Assurance (NCQA) - A not-for-profit organization that performs quality-oriented accreditation reviews on health maintenance organizations and similar types of managed care plans. HEDIS and the Quality Compass are registered trademarks of NCQA.

National Response Framework - Part of the Federal Emergency Management Agency (FEMA), The National Response Framework presents the guiding principles that enable all response partners to prepare for and provide a unified national response to disasters and emergencies. The framework establishes a comprehensive, national, all-hazards approach to domestic incident response.

Network – As utilized in the RFP, "network" may be defined as a group of participating providers linked through subcontractual arrangements to 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 agreement with the CCN.

Non-Covered Services - Services not covered under the Title XIX Louisiana State Medicaid Plan.

Non-Emergency - An encounter by a CCN member who has presentation of medical signs and symptoms, to a health care provider

Non-Emergency Medical Transportation (NEMT) - A ride, or reimbursement for a ride, provided so that a member with no other transportation resources can receive services from a medical provider. NEMT does not include transportation provided on an emergency basis, such as trips to the emergency room in life threatening situations.

Non-Participating Physician - A physician licensed to practice that has not contracted with or is not employed by the 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 48-72 hours of member notification of a non-urgent condition, as clinically indicated.

Nurse Practitioner (NP) - An advanced practice registered nurse educated in a specified area of care and certified according to the requirements of a nationally recognized accrediting agency such as the American Nurses Association's American Nurses Credentialing Center, National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties, or the National Certification Board of Pediatric Nurse Practitioners and Nurses, or as approved by the state board of nursing and who is authorized to provide primary, acute, or chronic care, as an advanced nurse practitioner acting within his/her scope of practice to individuals, families, and other groups in a variety of settings including, but not limited to, homes, institutions, offices, industry, schools, and other community agencies.

Open Enrollment - The period of time when a CCN member may change CCNs without cause *(once per year after initial enrollment)*.

Open Panel - means 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 core benefits and 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 (Appendix #B of this RFP).

Out-of-Network (OON) Provider - means an appropriately licensed individual, facility, agency, institution, organization or other entity that has not entered into a contract with the 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 Member Per Month (PMPM) – The amount of money paid or received on a monthly basis for each individual enrolled in the CCN.

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 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.

Performance Measures – Specific operationally defined performance indicators utilizing data to track performance and quality of care and to identify opportunities for improvement related important dimensions of care and service.

Personal Health Record (PHR) – A health record that is initiated and maintained by an individual.

Pharmacy Benefits – For the purposes of this RFP and exclusion from core benefits and services, pharmacy benefits are defined as prescription drugs that are dispensed by pharmacies.

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 medical 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 422.113(c)(1), Social Security 1852(d)(2) and 42 CFR § 438.114(a).

Potential Enrollee - 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 HHS for the purpose of determining financial eligibility for certain programs including Medicaid and CHIP and which are based on household size.

Pre-Certification - Review conducted prior to a member's utilization of a l service or course of treatment in a hospital or other facility.

Prepaid Model -A method of paying a CCN for the cost of health care services in advance of their use. A method providing in advance for the cost of predetermined benefits for a population group, through regular periodic payments in the form of premiums, dues, or contributions.

Preventive Care – Refers to the treatment to avert disease/illness and/or its consequences. The term is used to designate prevention and early detection programs rather than restorative or treatment programs. There are three levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred; requires a face-to-face visit within 4 weeks of member request.

Primary Care 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.

Primary Care Case Management – A system under which an entity contracts with the state to furnish 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 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.

Prior Authorization - The process of determining medical necessity for specific services before they are rendered.

Privacy Rule (45 CFR Parts 160 & 164) – Standards for the privacy of individually identifiable health information.

Prospective Review - Utilization review conducted prior to an admission or a course of treatment.

Protected Health Information (PHI) – Individually identifiable health that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Part 160 and 164.

Provider – Either (1) for the 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 Appeal The formal mechanism which allows a provider the right to appeal a CCN final decision.

Provider Complaint - A verbal or written expression by a provider which indicates dissatisfaction or dispute with CCN policy, procedure, claims processing and/or payment, or any aspect of CCN functions.

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 Preventable Condition (PPC) – Preventable hospital and non hospital-acquired conditions and events identified by DHH for nonpayment to ensure high quality of Medicaid services. PPCs allow for the provision of care and services in the best interest of eligibles and to provide for payment that is consistent with efficiency, economy and quality of care. PPCs are inclusive of health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPSCs).

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-P 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.

RFP (Request for Proposals) – As relates to CCN, the process by which DHH invites proposals from interested parties for the procurement of specified services.

Readiness Review – Refers to DHH's assessment of the CCN-P'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.

Re-admission - Subsequent admissions of a patient to a hospital or other health care institution for treatment.

Recipient - An individual entitled to benefits under Title XIX or Title XXI of the Social Security Act, and under the Louisiana Medicaid State Plan who is or was enrolled in Medicaid and on whose behalf a payment has been made for medical services rendered.

Redacted Proposal – The removal of confidential and/or proprietary information from one copy of the proposal for public records purposes**.**

Referral Services - 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.

Registered Nurse (RN) – Person licensed as a Registered Nurse by the Louisiana State Board of Nursing.

Reinsurance – Insurance a CCN purchases to protect itself against part or all of the losses incurred in the process of honoring the claims of members; also referred to as "stop loss" insurance coverage.

.**Related Party** - A party that has, or may have, the ability to control or significantly influence a contractor/subcontractor, or a party that is, or may be, controlled or significantly influenced by a contractor/subcontractor. "Related parties" include, but are not limited to, agents, management employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.

Relationship - Relationship is described as follows for the purposes of any business affiliations discussed in Section § 5: 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 obligations under its contract with the state.

Remittance Advice – An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only. Transactions may include but are not limited to, members enrolled in the CCN, payments for maternity, and adjustments.

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.

Representative - Any person who has been delegated the authority to obligate or act on behalf of another. Also known as the authorized representative.

Responsible Party – An individual, often the head of household, who is authorized to make decisions and act on behalf of the Medicaid recipient. This is the same individual that completes and signs the Medicaid application on behalf of a covered individual, agreeing to the rights and responsibilities associated with Medicaid coverage.

Risk - The chance or possibility of loss. The member is at risk only for pharmacy copayments as allowed in the Medicaid State Plan and the cost of non-covered services. The CCN, with its income fixed, is at risk for whatever volume of care is entailed, however costly it turns out to be. Risk is also defined in insurance terms as the possibility of loss associated with a given population.

Risk Adjustment - A method for determining adjustments to the PMPM rate that accounts for variation in health risks among participating CCNs when determining capitation payments.

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 LL 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 –hospital licensed by DHH which meets the definition in 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 "Covered Services."

Second Opinion - Subsequent to an initial medical opinion, an opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed health service, to assess the clinical necessity and appropriateness of the initial proposed health service.

Secondary Care - 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 – **(Referred to as Geographic Service Area (GSA) in this RFP). T**he designated geographical service area(s) in 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, including a service requested by the CCN member. 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 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 terms and conditions with DHH. The span of control also includes systems and telecommunications capabilities outsourced by the CCN.

Special Health Care 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.

Stabilized - With respect to an emergency medical condition; that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to a woman in labor, the woman has delivered (including the placenta).

Start-Up Date – The date CCN providers begin providing medical care to their Medicaid members. Also referred to as operations start date and "go-live :date.

State - The state of Louisiana.

State Plan – Refers to the Louisiana Medicaid State Plan.

Stratification - The process of partitioning data into distinct or non-overlapping groups.

Subcontractor - A person, agency or organization with which 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.

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 untilit 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.

System Unavailability – 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.

TTY/TTD – Telephone Typewriter and Telecommunication Device for the Deaf, which allows for interpreter capability for deaf callers.

Targeted Case Management – Case management for a targeted population of persons with special needs described in the Louisiana Medicaid State Plan.

Tertiary Care – Highly specialized medical care, usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities.

Third Party Liability (TPL) - Refers to the legal obligation of third parties, *i.e*., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a state plan.

Timely – Existing or taking place within the designated period; within the time required by 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 - includes all activities the CCN is required to perform between the Contract effective date and the implementation date for the CCN Program in a GSA.

Turnover Phase – includes all activities the CCN is required to perform in conjunction with the end of the Contract.

Turnover Plan - means the written plan developed by the CCN, approved by DHH, to be employed during the turnover phase.

Universal Rate - The PMPM rate initially paid to CCNs prior to the first risk adjustment, calculated using fee-for-service (FFS) data for the entire CCN population.

Urban Area – Refers to a geographic area that meets the definition of urban area at § 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 t*he* 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.

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.

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.

Week - The DHH seven-day work week, Monday through Sunday.

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

CNM – Certified Nurse Midwife

COB – Coordination of Benefits

CPT – Current Procedural Terminology

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

DOI – Louisiana Department of Insurance

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 –United States Department of Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act

HITECH – Health Information Technology for Economic and Clinical Health Act

HMO – Health Management Organization

IBNR – Incurred But Not Reported

IDEA – Individuals with Disabilities Education Act

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

MLR – Medical Loss Ratio

MVA – Medical Vendor Administration

NAIC – National Association of Insurance Commissioners

NCQA –National Committee for Quality Assurance

NEMT – Non-Emergency Medical Transportation

NP – Nurse Practitioner

NPI –National Provider Identifier

OON – Out of Network Provider

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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LIST OF CCN COMPANION GUIDES

1. **Financial Reporting Companion Guide**
2. **CCN-P Quality Companion Guide (TBE)**
3. **State Fair Hearing Companion Guide**

Note: The Quality Companion Guide is still in development and will be made available to contract CCNs prior to the Operations Start Date.