REQUEST FOR PROPOSALS

ENROLLMENT BROKER
FOR
LOUISIANA MEDICAID COORDINATED CARE NETWORKS

MEDICAID COORDINATED CARE SECTION
MEDICAL VENDOR ADMINISTRATION
DEPARTMENT OF HEALTH AND HOSPITALS

RFP # 305PUR-DHHRFP

Proposal Due Date/Time: 6/17/2011 (4:00 PM CDT)

Release Date: April 29, 2011

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APPENDICES

GLOSSARY

The following terms, as used in this RFP, shall be construed and interpreted as follows unless the context clearly requires otherwise.

Abuse – Related to Medicaid Program Integrity, in accordance with 42 CFR §455.2, means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Recipient practices that result in unnecessary cost to the Medicaid program are also included.

Action - The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service, the failure to provide services in a timely manner (as defined by DHH), and the failure of the managed care entity 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 managed care entity, the denial of a member's right to obtain services outside the provider network, as described in §438.52(b)(2)(ii).

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.

Automatic Assignment (CCN) – The process utilized to enroll into a CNN, using predetermined algorithms, a Medicaid eligible who 1) is not excluded from CCN participation and 2) does not proactively select a CCN within the DHH specified timeframe.

Automatic Assignment GNOCHC – The process utilized to enroll into a GNOCHC, using predetermined algorithms, a GNOCHC eligible who does not proactively select a CCN within the DHH specified timeframe.

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 program.

Business Day – Traditional workdays, including Monday, Tuesday, Wednesday, Thursday and Friday and the traditional work hours are 8 a.m. to 5 p.m. (Central Standard Time). State holidays are excluded. For a list of Louisiana state holidays, see the following website:
http://www.civilservice.la.gov/OtherInfo/StateEmployeesInfo/bene%20HOLIDAYS.asp

The Consumer Assessment of Healthcare Providers Systems (CAHPS) - A standardized survey of members' experiences with ambulatory and facility-level care established by the Agency for Healthcare Research and Quality (AHRQ).
Calendar Days — All seven (7) days of the week. Unless otherwise specified, the term "days" in this ***RFP*** refers to calendar days.

Cause — Specified reasons that allow mandatorily enrolled CCN members to change their CCN choice or mandatorily enrolled GNOCHC members to change their GNOCHC PCMH choice. Term may also be referred to as "good cause."

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)

Choice Counseling – Enrollment Broker activities such as answering questions and providing information in an unbiased manner on available CCNs and GNOCHC PCMHs and advising potential enrollees/enrollees on what factors to consider when choosing among them.

Cold Call Marketing – Any unsolicited personal contact with eligibles, its staff, its volunteers or its vendors/contractors with the purpose of influencing the Medicaid or GNOCHC eligible individual to enroll in the or either to not enroll in or disenroll from managed care program.

Complaint - Any communication a member has in which displeasure is expressed.

Contract - As it pertains to the Louisiana Department of Health and Hospitals (DHH) and the Enrollment Broker, the Contract signed by or on behalf of the Enrollment Broker entity and those things established or provided for in R.S. 46:437.11-437.14 or by rule, which enrolls the entity in the Medical Assistance Program and grants to the entity provider number and the privilege to participate in the CCN or GNOCHC program. It includes the signed Contract, together with any and all future addendums issued thereto by DHH.

Contract Dispute - A circumstance whereby the EB and DHH are unable to arrive at a mutual interpretation of the requirements, limitations, or compensation for the performance of services under the contract.

Contract Year – As defined in this RFP, August 1st through July 31st.

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) - A managed care entity that may be either an MCO or PCCM 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.

Covered Services - Those health care services/benefits to which an individual eligible for Medicaid is entitled under the Louisiana Medicaid State Plan or an individual eligible for GNOCHC is entitled under the GNOCHC Medicaid Section 1115(a) Demonstration Waiver Program.

Department (DHH) – The Louisiana Department of Health and Hospitals, referred to as DHH throughout this RFP.

Department of Health and Human Services (DHHS; also HHS) - The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

Disenrollment - Action taken by DHH or its designee to remove a Medicaid CCN member from the CCN or GNOCHC PCMH member from a GNOCHC PCMH 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, the CCN Program or the GNOCHC Program.

Direct Marketing/Cold Call - Any unsolicited personal contact with or without solicitation of a Medicaid eligible in person, through direct mail advertising or telemarketing by an employee or agent of the CCN or GNOCHC PCMH for the purpose of influencing an individual to enroll with the CCN or GNOCHC PCMH.

Eligibility Determination - The process for which an individual may be determined eligible for the Medicaid, Medicaid-expansion CHIP, or GNOCHC program.

Eligible - An individual determined eligible for assistance in accordance with the Medicaid State Plan(s) under the Title XIX or Title XXI of the Social Security Act or the GNOCHC Medicaid Section 1115(a) Demonstration Waiver Program or other waiver program.

Enrollee – Louisiana Medicaid eligible (recipient) who is currently enrolled in a CCN or for the purposes of this RFP GNOCHC eligible (recipient) who is currently enrolled in a GNOCHC PCMH.

Enrollment - -The process conducted by the Enrollment Broker by which an eligible Medicaid recipient becomes a member of a CCN or eligible GNOCHC recipient becomes a member of a GNOCHC PCMH.

Enrollment Activities – means activities such as but not limited to distributing, collecting, and processing enrollment materials and taking enrollments by phone or in person.

Enrollment Broker – The state's contracted or designated agent that performs functions related to outreach, education, choice counseling, enrollment and disenrollment of potential enrollees into a DHH managed care program.

Enrollment Services – mean services provided in accordance with provisions set forth in Title XIX of the Social Security Act and Louisiana Medicaid Program, their attendant regulations, guidelines and policies. Services include but are not limited to choice counseling, and enrollment activities.

FFP – Federal Financial Participation - 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.

Fiscal Intermediary (FI) - DHH's designee or agent responsible in the fee-for-service delivery model for an array of support services including MMIS development and support, claims processing, pharmacy support services, provider support services, financial and accounting systems, prior authorization and utilization management, fraud and abuse systems, and decision support.

Fiscal Year (FY) – Refer to budget year - Federal Fiscal Year: October 1 through September 30 (FFY); State Fiscal Year (SFY): July 1 through June 30.

Fraud – As relates to the Medicaid Program Integrity, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law. Fraud may include deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received.

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 - The designated geographical service area in which a CCN is authorized by contract with DHH to deliver core benefits and services to Medicaid enrollees or a GNOCHC PCMH is authorized by contract with DHH to deliver core benefits and services to GNOCHC enrollees. The minimum geographic service area a CCN may provide core benefits 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. The minimum geographic service area a GNOCHC PCMH may provide core benefits shall be Orleans, Jefferson, St. Bernard or Plaquemines Parish.

Good Cause – see "Cause".

GNOCHC Program – The Greater New Orleans Community Health Connection is a Section 1115(a) Medicaid Demonstration Waiver Program that provides limited benefits/covered services to eligible individuals under the Demonstration for the period October 1, 2010 through December 31, 2013.

GNOCHC Eligible – Refers to an individual determined eligible for the GNOCHC program. Eligibles for the GNOCHC program are individuals who are uninsured for at least six months; not pregnant; between 19 and 64 years old; not eligible for Medicaid, CHIP or Medicare; a resident of Orleans, St. Bernard, Jefferson, or Plaquemines Parish; with family income up to 200% FPL; and, meet the U.S. citizenship requirements under the Deficit Reduction Act and Children's Health Insurance Program Reauthorization Act.

GNOCHC PCMH – A GNOCHC participating provider which GNOCHC enrollees may choose, or be assigned to if they do not choose, as a Patient Centered Medical Home to provide primary care and care coordination services to the enrollee.

GNOCHC 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 GNOCHC Program, who may or may not be currently enrolled in the GNOCHC Program**,** and on whose behalf payment is made.

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 Provider - a health care professional or entity that provides health care services or goods.

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.

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 Medicaid State Plan – The binding written agreement between DHH and CMS which describes how the Medicaid program is administered and determines the services DHH will receive federal financial participation.

Managed Care Entity – A provider that provides managed care services or other coordinated care services as defined by DHH. As relates to this RFP a managed care entity will include a Coordinated Care Network, GNOCHC Program, or other alternative managed care program DHH may establish.

Managed Care Program - Any system that manages healthcare delivery with the aim of coordinating care to improve health outcomes.

Managed Care System - System of financing and delivering health care to enrollees organized around managed care techniques and concepts, including but not limited to care coordination.

Marketing - means any communication by a managed care entity to a potential enrollee who is not enrolled in the managed care entity that can reasonably be interpreted as intended to influence the recipient to enroll in a particular managed care entity, 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 managed care entity that can reasonably be interpreted as intended to market to potential enrollees or members**.**

Mass Media - A method of public advertising that can create managed care program name recognition among a large number of Medicaid recipients and can assist in educating them about potential managed care entity 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 services provided under this RFP. A material changes includes, but is not limited to, changes in composition of the enrollment of a new population. DHH shall make the final determination as to whether a change is material.

Medicaid - A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving covered individuals.

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 Program, who is enrolled in the Medicaid 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 Program, who may or may not be currently enrolled in the Medicaid Program**,** and on whose behalf payment is made.

Medical Home – Case management led by a primary care provider within a CCN who partners 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 Vendor Administration (MVA) – Refers to the name for the budget unit specified in the Louisiana state budget which contains the administrative component of the Bureau of Health Services Financing (Louisiana's single state Medicaid agency).

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 this RFP refers to a Medicaid eligible who enrolls in managed care program (e.g. CCN or GNOCHC); also refers to "enrollee" as defined in 42 CFR § 438.10(a).

Member Month – A month of coverage for a Medicaid eligible who is enrolled in a managed care program.

Medicaid Management Information System (MMIS) – Mechanized claims processing and information retrieval system which all state Medicaid programs are required to have and which must be approved by the Secretary of HHS. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid Providers and Eligibles.

Monetary Penalties – Monetary sanctions that may be assessed whenever the Enrollment Broker and/or its contractors fail to achieve certain performance standards and other items defined in the terms and conditions of the RFP.

Must - Denotes a mandatory requirement

Newborn - A live infant born to a CCN member.

Open Enrollment - The period of time when a member may change managed care entity member may change GNOCHC PCMHs without cause *(once per year after initial enrollment)*.

Ownership Interest - The possession of stock, equity in the capital, or any interest in the profits of the Enrollment Broker, for further definition see 42 CFR 455.101.

Per Member Per Month (PMPM) Rate – The monthly amount paid to the Enrollment Broker for each individual enrolled in managed care program.

Performance Measures – Specific operationally defined performance indicators utilizing data to track performance and quality of services and to identify opportunities for improvement.

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**.**

Potential Enrollee - A Medicaid eligible 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.

Primary Care Provider (PCP) - An individual physician or other licensed nurse practitioner responsible for the management of a member's health care who is licensed and certified in one of the following general specialties; family practitioner, general practitioner, general pediatrician, general internal medicine, general internal medicine and pediatrics, or obstetrician/ gynecologist. The primary care provider is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care), or admit the patient to a hospital.

Privacy Rule (45 CFR Parts 160 & 164) – Standards for the privacy of individually identifiable health information.

Procurement Library - A repository of manuals, statutes, rules and other reference material referred to in this RFP located in DHH's Administrative Offices in the Bienville Building, Baton Rouge, Louisiana or in electronic format and accessible at www.MakingMedicaidBetter.com

Proposer – Entity or company seeking a contract to provide stated deliverables and services identified within RFP document.

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 Parts 160 and 164

Provider – Either (1) for the Fee-For-Service Program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the CCN Program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers services; or for the GNOCHC Program, any individual or entity furnishing GNOCHC services under an agreement with the Medicaid agency; or (3) for an alternative managed care program, any individual or entity furnishing services under an agreement with the Medicaid agency.

Quality – As it pertains to external quality review means the degree to which an EB, through the provision of effective outreach services, increases the likelihood an enrollee will proactively choose a managed care entity as compared to being automatically assigned.

Quality Management (QM) – The ongoing process of assuring that the delivery of services are appropriate, timely, accessible, available and in keeping with established guidelines and standards.

Readiness Review – Refers to DHH's assessment of the EB's ability to fulfill the RFP requirements. Such review may include but not be limited to review of proper licensure; operational protocols, review of EB 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 EB's ability and readiness to render services.

Recipient - An individual entitled to benefits under Title XIX or Title XXI of the Social Security Act, and under the Louisiana Medicaid State Plan who is or was enrolled in Medicaid and on whose behalf a payment has been made for medical services rendered; or an individual entitled to benefits under the GNOCHC Section 1115(a) Demonstration Waiver who is or was enrolled in the GNOCHC program 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.

Related Party - A party that has, or may have, the ability to control or significantly influence a subcontractor, or a party that is, or may be, controlled or significantly influenced by a 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 this RFP: A director, officer, or partner of the EB; A person with beneficial ownership of five percent or more of the EB's equity; or a person with an employment, consulting or other arrangement (e.g., providers) with the EB obligations under its contract with the State.

Representative - Any person who has been delegated the authority to obligate or act on behalf of another. Also known as an authorized representative.

Risk - The chance or possibility of loss. Risk is also defined in insurance terms as the possibility of loss associated with a given population.

Section 1115(a) Medicaid Demonstration Waiver – A Demonstration program authorized under section 1115(a)(2) of the Social Security Act which allows identified expenditures made by the State, which are not otherwise included as expenditures under section 1903 of the Act, incurred during the period of the Demonstration, to be regarded as expenditures under the States title XIX plan, and does not apply expressly identified requirements of the Medicaid program expresses in law, regulation and policy statement to the Demonstration population for the duration of the Demonstration.

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 – The designated geographical area within which the CCN or GNOCHC PCMH is authorized to furnish covered services to enrollees.

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.

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 standard of financial health capable of meeting financial obligation.

Start-Up Date – The date the Enrollment Broker begins providing services to Medicaid and GNOCHC members. Also referred to as "effective date of contract".

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.

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 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).

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.

Will - Denotes a mandatory requirement.

ACRONYMS

BHSF – Bureau of Health Services Financing

CAHPS - The Consumer Assessment of Healthcare Providers and Systems

CAP – Corrective Action Plan

CMS – Centers for Medicare and Medicaid Services

CFR - Code of Federal Regulations.

CCN – Coordinated Care Network

DHH - Department of Health and Hospitals

DHHS – Department of Health and Human Services

EB – Enrollment Broker

FFP – Federal Financial Participation

FI – Fiscal Intermediary

FY – Fiscal Year

GNOCHC – Greater New Orleans Community Health Connection

GSA – Geographic Service Area

HIPAA – Health Information Portability Administration Act

IS – Information Systems

IT – Information Technology

MCO – Managed Care Organization

MVA – Medical Vendor Administration

MMIS – Medicaid Management Information System

MOA – Memorandum of Agreement

OCS – Office of Community Services

PMPM – Per Member, Per Month

PCMH – Patient Centered Medical Home

PCP – Primary Care Provider

PHI – Protected Health Information

QM – Quality Management

RFP – Request for Proposals

SFTP – Secure File Transfer Protocol

TDD/TTY – Telecommunication Device for the Deaf/Tele Typewriter

URAC – Utilization Review Accreditation Commission

1. GENERAL INFORMATION

1.1. Background

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

1.1.2. DHH is comprised of the Bureau of Health Services Financing (BHSF) which is the single state Medicaid agency, Office for Citizens with Developmental Disabilities, Office of Behavioral Health, Office of Aging and Adult Services, and the Office of Public Health. 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, a financial office known as the Office of Management and Finance, and various bureaus and boards. The Office of the Secretary is responsible for establishing policy and administering operations, programs, and affairs.

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, and Eligibility Systems, Health Standards, and National Health Care Reform. The Medicaid Coordinated Care Section has primary responsibility for implementation and ongoing operations of all Medicaid coordinated care delivery models, including CommunityCARE 2.0 (CC 2.0), comprehensive prepaid coordinated care and shared saving models through Coordinated Care Networks (CCNs) or alternative Medicaid managed care model that coordinates care and that the department makes available in accordance with the promulgation of administrative rules. The National Health Care Reform Section has primary responsibility for implementation and ongoing operations of the GNOCHC Program.

1.2. Purpose of RFP

1.2.1. The purpose of this Request for Proposals (RFP) is to solicit proposals from qualified proposers for Enrollment Broker (EB) (hereafter referred to as EB in this RFP) services that would provide enrollment services to GNOCHC, CCN or alternative Medicaid managed care program enrollees in accordance with the terms and conditions set forth herein.

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

1.2.3. Through this RFP, the Department seeks to contract for the needed services and to give qualified businesses, including those that are owned by minorities, women, persons with disabilities, and small business enterprises, opportunity to do business with the State as contractors and subcontractors. DHH is seeking to procure services, in connection with, the operation and maintenance of a statewide enrollment system for the Medicaid Coordinated Care Network Program and GNOCHC Program.

1.2.4. DHH's objectives for the RFP are designed to optimize the operation of the program for which the services are being procured. The objectives are:

1.2.4.1. To implement an enrollment process that provides choice counseling and member materials for potential enrollees and enrollees to ensure enrollees may make an informed choice in the selection of their managed care provider, with multiple access channels to enroll and necessary administrative supports to timely handling of member inquiries. The enrollment process must allow clients the opportunity for self-service by maximizing access through a web-based approach that is supplemented by additional electronic means, including but not limited to e-mail, facsimile, and Interactive Voice Response (IVR);

1.2.4.2. To provide for call center operations that utilize telephony infrastructure and EB staff to respond to inquiries from potential enrollees and enrollees regarding CCNs and GNOCHC PCMHs;

1.2.4.3. To implement a disenrollment process for enrollees under the CCN and GNOCHC programs served under this RFP; and

1.2.4.4. To develop and maintain systems required to communicate with CCNs, DHH's Fiscal Intermediary (FI) and others entities; electronically transfer data, maintain enrollment records, CCN provider network, directories and develop reports as specified by DHH.

1.2.5. This RFP process is being used so that the Department may selectively contract with one qualified entity. The RFP will provide the Department with the opportunity to ensure that the potential EB is capable of implementing an acceptable enrollment management system.

1.2.6. 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. State authority to implement the GNOCHC Program is contained in the special terms and conditions and expenditure authorities constituting the agreement between DHH and CMS for the GNOCHC section 1115(a) Demonstration waiver program (Project Number 11-W-00252/6).

1.3. Federal Authority

1.3.1. 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 it pertains to managed care and enrollment brokers; DHH intends to submit a State Plan Amendment to implement the CCN program.

1.3.2. Federal authority to implement the GNOCHC Program is contained in the special terms and conditions and expenditure authorities constituting the agreement between DHH and CMS for the GNOCHC section 1115(a) Demonstration Waiver Program (Project Number 11-W-00252/6).

1.4. Invitation to Propose

DHH is inviting qualified proposers to submit proposals to provide a specified scope of services for eligible enrollees in the CCN, GNOCHC and any alternative managed care program the Department my implement in return for a per member per month fee, in accordance with the specifications and conditions set forth herein.

1.5. RFP Coordinator

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

Veronica Dent
Medicaid Program Manager
Medicaid Coordinated Care Section
Department of Health and Hospitals
628 North 4th Street, 7th Floor
Baton Rouge, LA 70802
Phone: 225–342-0327
Fax: 225-376-4777
Email: Veronica.Dent@la.gov

1.5.2. This RFP is available in pdf at the following weblinks:

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

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

1.6. Proposer Comments

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

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

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

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

1.6.4. 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[dwv1] and
http://wwwprd.doa.louisiana.gov/OSP/LaPAC/bidlist.asp?department=4, and
http://www.makingmedicaidbetter.com

1.6.5. The State reserves the right to determine, at its sole discretion, the appropriate and adequate responses to written comments, questions, and requests for clarification. The State'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 the Department. 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:

- Company Name
- Name and title of a contact person

- Mailing address, email address, telephone number, and facsimile number of the contact person

NOTICE: A Notice of Intent to Propose creates no obligation and is not a prerequisite for making a proposal. However entities submitting a Notice of Intent to Propose will receive e-mail notification of the Internet posting of RFP addendums and other communications regarding the RFP, as well as a CD with electronic documents in the Procurement Library.

1.8. Proposal Conference

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

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 the state will be stated in writing in response to written questions. Therefore, proposers should submit all questions in writing (even if an answer has already been given to an oral question). After the conference, questions will be researched and the official response will be posted on the Internet at the following weblink:

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

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	4/29/2011
Pre-Proposal Conference	5/5/2011
Deadline for Receipt of Written Questions	5/12/2011 @ 4:00 pm CDT (hand delivery and mail) or @ 11:00 pm CDT (e-mail only)
Response to Written Questions	5/27/2011

Schedule of Events	Tentative Schedule
Deadline for Receipt of Written Proposals	6/17/2011 4:00pm CDT
Proposal Evaluation Begins	6/20/2011
Contract Award Announced	7/7/2011
Contract Negotiations Begin	7/8/2011
Contract Begins	8/1/2011
Deadline Date Successful Transfer of Recipient File from FI for Creation of Choice Letters	11/1/2011
Deadline Date for Successful Completion of 834 file transfer for Phase 1 CCNs	11/15/2011

1.10. RFP Addenda

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

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

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2. ELIGIBILITY AND INCLUDED POPULATIONS

2.1. CCN Populations

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

Eligibility criteria for the Louisiana Medicaid CCN Program are the same as the eligibility criteria for the Louisiana Medicaid and CHIP Programs. Children enrolled in Medicaid or CHIP have 12 months continuous eligibility, regardless of changes in income or household size. Individuals who attain eligibility due to a pregnancy are guaranteed eligibility for comprehensive services through two months post-partum or post-loss of pregnancy. Renewals of 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 SNAP benefits, and telephone renewals.

2.1.1. Mandatory Populations

Medicaid groups mandated to participate in CCN include the following: {42 CFR §438.1(a)(5)(i)}

2.1.1.1. Children under 19 years of age including those who are eligible under Section 1931 poverty-level related groups and optional groups of older children in the following categories:

- **Section 1931 - (Low Income Families with Children)** - Individuals and families who meet the eligibility requirements of the AFDC State Plan in effect on July 16, 1996;
- **TANF** - Individuals and families receiving cash assistance through FITAP, administered by the DCFS;
- **CHAMP-Child Program** – Poverty level children up to age 19 with income at our below 100% FPL for children 6 to 19 and at or below 133% FPL for children age 0 to 6, who meet financial and non-financial eligibility criteria. Deprivation or uninsured status is not an eligibility requirement;
- **Deemed Eligible Child Program** - Infants born to Medicaid eligible pregnant women, regardless of whether or not the infant remains with the birth mother, throughout the infant's first year of life;

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

- **Regular Medically Needy Program** - Individuals and families who have more income than is allowed for regular on-going Medicaid but below the Medically Needy Income Eligibility Standard (MNIES)

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

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

- Section 1931 LIFC Program

- TANF (FITAP) Program

- Regular Medically Needy Program

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

- **LaMOMS (CHAMP-Pregnant Women)** - Pregnant women otherwise ineligible for Medicaid with family income at or below 200% FPL who receive coverage for prenatal care, delivery, and care sixty (60) days after delivery and

- **LaCHIP Phase IV Program** – Separate State CHIP Program for CHIP Unborn Option which covers uninsured pregnant women ineligible for Medicaid, with family income at or below 200% FPL from conception to birth.

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

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

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

(Supplemental Security Income) administered by the Social Security Administration and

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

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

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

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

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

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

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

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

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

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

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

2.1.2. Voluntary Populations

2.1.2.1. Children under 19 years of age who are:

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

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

- The Indian Health Service; or

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

2.1.3. Excluded Populations

Medicaid eligibles that cannot voluntarily enroll with a CCN excluded include:

2.1.3.1. Individuals receiving hospice services;

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

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

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

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

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

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

2.1.3.7. Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE), a community-based alternative to placement in a nursing facility that includes a complete "managed care" type benefit combining medical, social and long-term care services;

2.1.3.8. Individuals with a limited eligibility period including:

- Spend-down Medically Needy Program - An individual or family who has income in excess of the prescribed income standard can reduce excess income by incurring medical and/or remedial care expenses to establish a temporary period of Medicaid coverage (up to three months); and
- Emergency Services Only - Emergency services for aliens who do not meet Medicaid citizenship/ 5-year residency requirements;

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

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

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

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

2.1.4. GNOCHC Population

Eligibility for the GNOCHC Program is different from the eligibility criteria for the CCN Program. See Glossary for definition of GNOCHC eligible.

2.1.4.1. Mandatory GNOCHC Populations

All individuals who are eligible under the GNOCHC Demonstration.

2.1.5. Other Populations

DHH reserves the right to add or remove populations to be enrolled in the CCN Program or alternative managed care program that may be developed by DHH.

2.2. Duration of Eligibility

2.2.1. CCN Eligibility

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

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

2.2.1.3. Renewals of Medicaid and CHIP eligibility are conducted annually and do not require a face-to-face interview or signed application as DHH may conduct ex parte renewals, Express Lane Eligibility (ELE)

renewals for children under age 19 receiving Supplemental Nutrition Assistance Program (SNAP) benefits, and telephone renewals.

2.2.2. GNOCHC Eligibility

2.2.2.1. Adults 19 through 64 years old receive 12 months continuous eligibility, unless the enrollee voluntarily withdraws from the program; no longer resides in Orleans, Jefferson, St. Bernard or Plaquemines Parish; becomes incarcerated or becomes an inpatient in an institution for mental disorders; becomes eligible for Medicaid or CHIP; obtains creditable health insurance and/or Medicare; turns 65 years old; or dies.

2.2.2.2. Renewals of GNOCHC eligibility are conducted annually and do not require a face-to-face interview or signed application as DHH may conduct ex parte renewals and telephone renewals.

2.2.3. Other Populations

The Department reserves the right to provide eligibility of providing the eligibility information as populations are approved by CMS.

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3. GENERAL REQUIREMENTS

3.1. Project Overview

3.1.1. The procurement invites qualified proposers to provide enrollment services for the comprehensive implementation and operation of Operations ("EB Services") and related support services in accordance with the specifications contained in this RFP.

3.1.2. This RFP, together with (i) any amendments issued by DHH prior to the due date for receipt of proposals, (ii) the contents of the Procurement Library located at www.MakingMedicaidBetter.com, and any other documents expressly designated by DHH prior to the due date for proposals as being part of the RFP, are referred to collectively as the "RFP".

3.1.3. As used in the RFP, "Enrollment Broker" means an individual or entity that performs enrollment services, which includes but is not limited to outreach and education, choice counseling and enrollment activities. See 42 CFR § 438.810. For purposes of this RFP, EB Services includes "enrollment services" as defined in 42 CFR § 438.810(a), as well as related services described in this RFP, whether or not such services are within the scope of enrollment services as defined in federal regulations.

3.1.4. The primary purpose of the EB is to assure that the target population receives timely and adequate information and education about managed care health care delivery systems, and to perform all functions directly related to the enrollment of the recipients with the managed care program of their choice of which they are eligible to participate.

3.1.5. In accordance with 42 CFR § 438.810f(a) EB activities shall be delivered by an external entity with no corporate connections or financial interest in any of the Louisiana contracted managed care entity.

3.1.6. The EB's call center must be physically located in the United States.

3.1.7. The EB shall ensure that the ongoing managed care enrollment process for eligible enrollees are consistent, effective and service oriented, continually pursuing opportunities for improvement. The Department and the EB shall monitor enrollment for EB objectivity by auditing of telephone calls and review of monthly plan change reports.

3.1.8. Enrollment options shall include enrollment requests through a variety of methods including, but not limited to, telephone toll-free number, web application and hard copy application. The proposal must describe in detail various options it will make available for the enrollment process, including but not limited to technology, staffing and any planned innovative processes. Additionally, the proposal must include a detailed implementation plan. The implementation plan must demonstrate the EB's proposed schedule to implement full operations within 30 days of contract award to successfully manage the requirements described in this RFP.

3.2. Meetings

Regular meetings will be scheduled by the Department with the EB. The EB may also request meetings. An agenda will be sent prior to the meetings with the topics to be discussed. A summary of the meeting will be distributed within ten (10) business days following the meeting. The EB will be responsible for the meeting summary preparation and distribution and obtaining approval from the Department.

3.3. Invoices

3.3.1. Invoices are due to the contract monitor no later than the tenth (10th) of the month following the month of rendering the invoiced services.

3.3.2. Invoices must identify Department cost centers and Federal/State match rate identified as directed by the Department.

3.4. Subcontracting

The EB shall not contract with any other party for furnishing any of the work and professional services required by the contract without the express prior written approval of the Department. The EB shall not substitute any subcontractor without the prior written approval of the Department For subcontractor(s), before commencing work, the EB will provide letters of agreement, contracts or other forms of commitment which demonstrates that all requirements pertaining to the EB will be satisfied by all subcontractors through the following:

3.4.1. The subcontractor(s) will provide a written commitment to accept all contract provisions.

3.4.2. The subcontractor(s) will provide a written commitment to adhere to an established system of accounting and financial controls adequate to permit the effective administration of the contract.

3.5. Insurance Requirements

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

3.5.1. EB's Insurance

The EB 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 the Department for approval. The EB shall not allow any subcontractor to commence work on subcontract until all similar insurance required for the subcontractor has been obtained and approved. If so requested, the EB shall also submit copies of insurance policies for inspection and approval of the Department before work is commenced Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days notice in advance to the Department and consented to by the Department in writing and the policies shall so provide.

3.5.2. Compensation Insurance

Before any work is commenced, the EB shall obtain and maintain during the life of the contract, Workers' Compensation Insurance for all of the EB's employees employed to provide services under the contract. In case any work is sublet, the EB shall require the subcontractor similarly to provide Workers' Compensation Insurance for all the latter's employees, unless such employees are covered by the protection afforded by the EB. In case any class of employees engaged in work under the contract at the site of the project is not protected under the Workers' Compensation Statute, the EB shall provide for any such employees, and shall further provide or cause any and all subcontractors to provide Employer's Liability Insurance for the protection of such employees not protected by the Workers' Compensation Statute.

3.5.3. Commercial General Liability Insurance

The EB shall maintain during the life of the contract such Commercial General Liability Insurance which shall protect the EB, the Department, 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 EB 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 the Department. Such insurance shall name the Department as additional insured for claims arising from or as the result of the operations of the Contactor or its subcontractors. 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.

3.5.4. Insurance Covering Special Hazards

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

3.5.5. Licensed and Non-Licensed Motor Vehicles

The EB 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 thereunder, unless such coverage is included in insurance elsewhere specified.

3.5.6. Subcontractor's Insurance

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

3.6. Resources Available to EB

The Department will have an assigned staff Member who will be responsible for primary oversight of the contract. This individual will schedule meetings to discuss progress of activities, and problems identified.

3.7. Contact Personnel:

All work will be performed under the direct supervision of:

Veronica Dent
Contract Monitor
Medical Vendor Administration
Coordinated Care Section
Bienville Building, 7th Floor
628 North 4th Street
Baton Rouge, LA 70802

3.8. Term of Contract

3.8.1. Effective Date

The contract effective date shall be August 1, 2011 through July 31, 2014; unless terminated prior to that date in accordance with state or federal law or terms of the contract.

3.8.2. Extensions

If the EB is in compliance with the contract terms and conditions and upon mutual agreement of both parties, this contract may be renewed for two (2) subsequent twelve month periods.

There may be an extension for an additional two (2) twelve (12) month periods 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 Ccntract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the contract.

3.9. Deliverables (Payments)

The EB shall submit deliverables in accordance with established timelines and shall submit itemized invoices monthly or as defined in the contract terms. Payment of invoices is subject to approval of the Department.

4. SCOPE OF WORK

4.1. Services

The EB's services will consist of, but not be limited to, the following:

4.1.1. Assist approximately 867,444 Medicaid and CHIP potential enrollees in initially enrolling into a CCN and assist enrolled members in maintaining their enrollment on an annual basis after initial implementation of the CCN Program. Beginning in January of 2014 there will be a potential for an additional 400,000 Medicaid eligibles due to expansion of Medicaid eligibility to parents and childless adults.

4.1.2. Assist approximately 50,000 GNOCHC recipients in initially enrolling into a GNOCHC PCMH and assist enrolled members in maintaining their enrollment on an annual basis after initial implementation of the GNOCHC PCMH Program. Upon expiration of the GNOCHC Demonstration on December 31, 2013, eligible individuals enrolled under the Demonstration will transition to Medicaid due to expansion of Medicaid eligibility to parents and childless adults.

4.1.3. Assist undetermined number of alternative managed care potential enrollees in initially enrolling into a managed care program and assist enrolled members in maintaining their enrollment on an annual basis after initial implementation.

4.1.4. Maximize enrollee choice through existing recipient and new enrollee outreach and education;

4.1.5. Assist and educate all managed care potential enrollees in their selection of the most appropriate managed care program, taking into account such factors as geographic parish of residence, recipient's health care needs, previous relationship with a managed care provider, the needs of the recipient's family members and managed care entity capacity;

4.1.6. Maintain the systems necessary to support all of the functional areas above while supporting Medicaid eligibles, enrolled members of the managed care entities, provider listings of managed care entities (as appropriate), and alternative managed care program members and providers (if applicable);

4.1.7. Provide timely and accurate management reporting that supports decision making for managed care programs;

4.1.8. Maximize the number of opportunities for potential enrollees and enrollees to obtain objective, unbiased information;

4.1.9. Assist DHH in providing superior enrollment materials to recipients and potential enrollees and enrollees that contain information to assist in the selection of a managed care entity; and

4.1.10. Incorporate a call center to support EB functions.

4.2. Coordination of Services

4.2.1. The EB shall coordinate and collaborate with the Making Medicaid Better Outreach and Education contractor and DHH to ensure Medicaid eligibles are informed, educated and provided the assistance they require to select an appropriate managed care entity to meet their medical requirements as stated in section 4.4.2 (Choice Counseling).

4.2.1.1. EB will utilize materials produced by the Outreach and Education contractor for outreach efforts, mailings or distributions to enrollees, in conjunction with materials produced by the Enrollment Broker contractor.

4.2.1.2. All messaging to enrollees will be coordinated with the Outreach and Education contractor though the DHH Communications Office and, in particular, the DHH Communications Director.

4.2.1.3. EB-designed materials shall incorporate the brand developed by the Making Medicaid Better Education and Outreach campaign. This shall be achieved by utilizing the Education and Outreach contractor materials as well as using templates and designs provided by the Outreach and Education contractor for EB created materials.

4.2.1.4. EB should observe and utilize the research from the Outreach and Education contractor focus groups.

4.2.1.5. Any instances that negatively affect member access to services may be grounds for contract cancellation or DHH determined monetary penalty.

4.2.1.6. In the event of a dispute, DHH decisions are final.

4.3. Conditions for Enrollment Brokers

In accordance with SSA 1903(b)(4)(A) and 42 CFR 483.810(a) the EB and its subcontractors shall meet the following conditions:

4.3.1. Independence

EB and its subcontractors shall be independent of any MCO, PIHP, PAHP, PCCM, or other health care provider in the State in which they provide enrollment services. EB or subcontractor is not considered “independent” if it-

4.3.1.1. Is an MCO, PIHP, PAHP, PCCM or other health care provider in the State;

4.3.1.2. Is owned or controlled by an MCO, PIHP, PAHP, PCCM, or other health care provider in the State; or

4.3.1.3. Owns or controls an MCO, PIHP, PAHP, PCCM, or other health care provider in the State.

4.3.2. Freedom from Conflict of Interest.

In accordance with SSA 1903(b)(4)(B) and 42 CFR §438.810(b), the EB and its subcontractor shall be free from any conflict of interest. The EB or subcontractor is not considered free from conflict of interest if any person who is the owner, employee, or consultant of the broker or subcontractor or has any contract with them:

4.3.2.1. Has any direct or indirect financial interest in any entity or health care provider that furnishes services in the State in which the broker or subcontractor provides enrollment services;

4.3.2.2. Has been excluded from participation under Title XVIII or Title XIX of the Social Security Act;

4.3.2.3. Has been debarred by any Federal agency; or

4.3.2.4. Has been, or is now, subject to civil money penalties under the Act.

4.3.3. Approval

The initial contract for services performed by the EB has been reviewed and approved by CMS. [67 FR 41095, June 14, 2002; 67 FR c65505, Oct. 25, 2002]

4.4. Programmatic Requirements

4.4.1. Enrollment and Disenrollment Process

4.4.1.1. The EB shall be the primary contact for all managed care eligibles:

4.4.1.1.1. for Medicaid eligibles concerning the selection of a CCN;

4.4.1.1.2. GNOCHC eligibles concerning the selection of a GNOCHC PCMH; or

4.4.1.1.3. Eligibles concerning the selection an alternative managed care program developed by DHH.

4.4.1.2. The objective of the enrollment/disenrollment process function is the efficient and timely enrollment of managed care eligibles.

4.4.1.3. The enrollment process shall include, at a minimum, policies and procedures that address Choice Counseling, Enrollment, and Disenrollment and Appendix J – CCN Eligibility, Enrollment and Disenrollment Requirements

4.4.1.3.1. The EB is required to send a letter to all Medicaid eligibles with a race code of "Native American" or "Alaskan Native", as identified on the eligibility file, requesting documentation of their tribal membership with a federally recognized tribe.

4.4.1.4. The EB shall comply with the rules and regulations concerning the enrollment and disenrollment procedures including but not limited to: notification requirements concerning disenrollment rights, enrollment rights, right to request and obtain information concerning enrollment/disenrollment; and provided such information in the timeframe specified by DHH.

4.4.2. Choice Counseling

4.4.2.1. The EB will accept eligibility files identifying managed care eligibles from DHH or its designee from which to generate a mail file for mailing of the enrollment packet within two (2) business days of receiving the eligibility file. The mail file must contain a special letter and flyer explaining the deadline to enroll. If the enrollment file has a managed care indicator, or the enrollee makes a choice prior to the receipt of the eligibility file, the enrollment packet shall not be sent.

4.4.2.2. The EB will inform the managed care potential enrollee of all managed care programs/networks available in their geographic service area (GSA). The EB shall comply with the information requirements of 42 CFR §438.10 to ensure that, before enrolling, the potential enrollee receives, from the EB, the accurate oral and written information he or she needs to make an informed decision. This information shall be provided in accordance with Social Security Act 1932 and 42 CFR §438.104, in an objective, non-biased fashion that neither favors nor discriminates against any managed care provider.

4.4.2.3. The EB will offer multiple approaches to managed care organization/network education and enrollment. The EB will support the following methods of enrollment:

a) Mail enrollment with inclusion of postage paid return envelope;

b) Web based enrollment;

c) Telephone enrollment and

d) Face-to-face, through outreach events.

4.4.2.4. The EB shall compile an enrollment packet, to be sent to all new eligibles. The appropriate enrollment packet will consist of all required information from each managed care program with a detailed comparison sheet outlining the specifics of each program, created by the EB. Each enrollment packets are distinctly different packets and are to be provided to the designated eligibility groups.

4.4.2.5. The EB will include a proposal to incorporate innovative outreach and education methods for each managed care program, including but not limited to, the design of an application for enrollment broker activities for a smart phone or tablet devices and the use of text messaging to communicate with enrollees.

4.4.2.6. The EB shall provide Medicaid eligibles with information regarding available managed care programs they may select and are eligible with information regarding the programs they may select through enrollment kits, letters or member packets.

4.4.2.7. The enrollment kits shall consist of DHH approved materials supplied by the DHH's Education and Outreach contractor and the EB to assist potential enrollees or enrollees in making an enrollment choice. Eligibles shall be offered multilingual enrollment material or materials in alternative formats, large print, and/or Braille when needed. This material must explain how to enroll in the managed care programs for which they are eligible to participate.

4.4.2.8. The EB will be responsible for the compilation of materials for each enrollment packets.

4.4.2.9. The EB will be responsible for the printing of materials for all enrollment packets for distribution to eligibles.

4.4.2.10. The CCN enrollment kit shall include, but is not limited to, the following:

a) CCN Comparison Chart, created by the EB;

b) CCN Brochure, provided by each CCN;

c) Welcome Letter, incorporating a style provided by the Education and Outreach contractor, but with language provided by the EB, and explaining the enrollment deadline;

d) Provider information, as determined by DHH.

4.4.2.11. The GNOCHC enrollment kit shall include, but is not limited to, the following:

a) GNOCHC comparison chart, created by the EB; and

b) Welcome letter.

4.4.2.12. DHH reserves the right to require the development of other managed care program enrollment kits as necessary for any alternative managed care program that may be developed.

4.4.2.13. The EB shall make enrollment kits available to eligibles electronically, and in hard copy through EB field staff, and at Medicaid eligibility offices and certified Medicaid Application Centers. Potential enrollees who attend a face-to-face presentation at any of these sites can take the enrollment kit home to review or discuss their options with other family members prior to selecting a managed care provider in the programs they are eligible.

4.4.2.14. The importance of early selection of a managed care entity shall be stressed, especially if the potential enrollee indicates priority health needs.

4.4.2.15. The EB shall identify forms received from eligibles that cannot be processed due to incomplete information or illegible information the same day forms are received or no later than the next business day, and generate a mail file for mailing of the Missing Information (MI) letter, as directed by DHH. The EB shall attempt to contact the potential enrollee by phone to obtain missing information if the EB is unable to reach the potential enrollee by phone; missing enrollment information shall be requested by mail.

4.4.2.16. The EB shall assist the potential enrollee with the selection of a managed care entity that meets the potential enrollee's needs. The EB must explain, in a non-biased manner, the criteria that may be considered when making a selection.

4.4.2.17. The EB shall inform potential enrollees that all members of a family unit will be required to select the same managed care entity unless extenuating circumstances warrant a different selection (e.g. if the child's pediatrician is in a different CCN). Such instances will be defined or approved by DHH.

4.4.2.18. The EB is responsible for identifying any barriers which hinder the enrollee and where special assistance is needed for visual and hearing impaired and members with physical or mental disabilities.

4.4.2.19. The EB will be responsible for surveying 20% of the new eligibles, on a quarterly basis, that failed to choose a managed care entity to determine the reason a selection was not made.

The EB shall produce a quarterly report to show the results of the survey. The report must include but not be limited to the following:

a) Name of Enrollee;

b) Enrollee Medicaid Number;

c) Eligibility Date; and

d) Reason for not pro actively selecting a CCN.

4.4.3. Proactive Member Selection of a CCN

4.4.3.1. The target goal for pro-active selection (enrollee choice) of a CCN is 80%. The EB shall be required to meet a minimum goal 51% or greater of member proactive selection during each phase of the initial enrollment of the CCN program; and for each contract year thereafter.

4.4.3.2. A contract year is defined as August 1st – July 31st.

4.4.3.3. The initial enrollment phases of the CCN Program shall be defined as the enrollment period for each CCN Geographic Service Area (GSA):

4.4.3.3.1. Phase 1 for GSA A: January 1, 2012;

4.4.3.3.2. Phase 2 for GSA B: March 1, 2012; and

4.4.3.3.3. Phase 3 for GSA C: May 1, 2012.

4.4.3.4. The choice calculations will be based on automatic assignments and shall be defined by DHH.

4.4.3.5. If the EB does not reach the minimum goal of 51% for each enrollment phase of the transition of Medicaid recipients to CCNs, a monetary penalty in the amount of $200,000 will be assessed for each of the three phases in which the goal is not attained.

4.4.3.6. The EB will be required to submit a corrective action plan (CAP) detailing the reasons for failure to attain a member proactive selection of CCN rate of 51%. The CAP must be received within ten (10) days after the calculation of the proactive selection of CCN percentage.

4.4.3.7. After the initial enrollment phases have been completed, the EB must submit an annual report which is due no later than 30days after the end of the contract year.

4.4.3.8. DHH will provide a financial incentive payment to the EB if the EB substantially exceeds the minimum goal of member proactive selection required in § 4.4.3.1 above.

The EB may be eligible for incentives for each phase of enrollment specified in §4.4.3.2 and §4.4.3.3 above.

a) The EB shall be eligible for a performance bonus in the amount of $100,000 if the EB meets or exceeds 70% pro-active selection by members; or

b) $200,000 if the EB meets or exceeds 80% and over pro-active selection by members.

4.4.4. Member-Related Materials

4.4.4.1. All member-related materials must be in a style and reading level that will accommodate the reading skills of eligibles. In general, the writing should be at not 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.

4.4.4.2. The text must be printed in at least ten-point font, preferably twelve-point font.

4.4.4.3. All enrollment notices, and informational and instructional materials shall be available upon request and prepared in a way that is easily understood by enrollees and potential enrollees.

4.4.4.4. The EB shall make written information available in the prevalent non-English languages.

4.4.4.5. The EB must make oral interpretation services available free of charge to each potential enrollee and enrollee and notify the enrollees:

- That oral interpretation is available in any language,
- That written information is available in prevalent languages; and
- how to access the interpretation services and written information.

4.4.4.6. Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

4.4.5. Enrollment Process

The EB shall be responsible for the following:

4.4.5.1. CCN Enrollment Process

4.4.5.1.1. Adhere to all Medicaid state and federal rules, regulations, policies and procedures regarding enrollment and reenrollment

for the CCN Program. See Appendix J – CCN Eligibility, Enrollment and Disenrollment Requirements.

4.4.5.1.2. Process CCN enrollments within the timeframe specified by DHH.

4.4.5.1.3. Accept all CCN and PCP choices as appropriate for Medicaid potential enrollees and enrollees.

4.4.5.1.4. Process and provide enrollee choices to applicable CCNs.

4.4.5.1.5. Establish a process that allows newborn CCN assignments to the mother's CCN, including but not limited to automatic assignment and plan change requests, as specified by DHH.

4.4.5.1.6. If the choice of CCN and PCP is not indicated on the new eligible file transmitted by DHH to the EB, the EB shall contact the responsible party for the new eligible to request their choice of CCN and if available the PCP of choice.

4.4.5.1.7. The EB shall encourage the continuation of any existing satisfactory provider/patient relationship with their current PCP who is in a CCN.

4.4.5.1.8. The name of the PCP requested by a responsible party for the new enrollee will be included in the Member File from the EB to CCN.

4.4.5.1.9. The CCN will be responsible for confirming the PCP selection information in a written notice to the member.

4.4.5.1.10. If the EB is unable to contact the responsible party for selection of a CCN and PCP, then the Newborn will be auto-assigned to the Mothers CCN and the Newborns name will be forwarded to the CCN without a specified PCP. The CCN will be responsible for contacting / assigning a PCP.

4.4.5.1.11. Upon receipt of the daily electronic enrollment files, the EB must review, identify and correct incomplete data fields within two (2) calendar days.

4.4.5.2. GNOCHC Enrollment Process

4.4.5.2.1. Process GNOCHC enrollments within the timeframe specified by DHH.

4.4.5.2.2. Accept all GNOCHC PCMH choices as appropriate for GNOCHC potential enrollees and enrollees.

4.4.5.2.3. Process and provide enrollee choices to applicable GNOCHC PCMHs.

4.4.5.2.4. Upon receipt of the daily electronic enrollment files, the EB must review, identify and correct incomplete data fields within two (2) calendar days.

4.4.5.3. Alternative Managed Care Program

The EB shall process enrollments as developed by DHH.

4.4.5.4. Automatic Assignment

4.4.5.4.1. The EB shall identify potential enrollees who have not identified their managed care choice within 30 calendar days from the postmark date that an enrollment letter is sent to them by the EB.

4.4.5.4.2. Potential enrollees/enrollees that fail to select within the thirty (30) day window shall be automatically assigned to a managed care entity utilizing the automatic assignment algorithm designed by DHH.

4.4.5.4.3. The automatic assignment algorithm takes into consideration the following factors:

a) The member's previous CCN;

b) 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.

c) 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.

d) 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.

e) Beginning in October 2014, the CCN's quality measures will be factored into the algorithm for automatic assignment.

4.4.5.4.4. GNOCHC PCMH automatic assignment algorithm shall take into consideration the following factors:

a) Inclusion in the GNOCHC Program of the member's historic provider as identified by Medicaid claims history. If the member has a historic provider relationship with more than one GNOCHC PCMH, the member will be assigned to the GNOCHC PCMH from which the enrollee last received services.

b) Inclusion in the GNOCHC Program of a family member's current or historic provider as identified by Medicaid claims history. If the family member has a current or historic provider relationship with more than one GNOCHC PCMH, the member will be assigned to the GNOCHC PCMH from which the family member last received services.

c) If neither the member nor a family member has a current or historic provider relationship, the member will be auto-assigned to a GNOCHC PCMH in the member's parish of residence, on a round robin basis.

4.4.5.4.5. Neither the Prepaid Coordinated Care Network Network(s) (CCN-P) nor the Shared Savings Network(s) (CCN-S) will be given preference in making auto assignments.

4.4.5.4.6. If an entity is operating both a Prepaid Network and a Shared Savings Network within a GSA, it will be treated as one entity for any round robin auto assignment purposes, with assignment made equally between the two. DHH will notify the EB when this is applicable.

4.4.5.5. Effective Date of Enrollment

Enrollment, whether by member choice or automatic assignment, for members assigned on or before the third (3rd) to last business 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 business day in a given month will be effective at 12:01AM on the first (1st) calendar day of the second (2nd) month following assignment.

4.4.5.6. Disenrollment

The EB shall adopt and adhere to DHH's approved procedures for member, GNOCHC PCMH and CCN initiated disenrollment requests**.**

4.4.5.6.1. Member Disenrollment Requests For Cause

A member may request for cause, at any time. The following circumstances are cause for disenrollment:

- The member moves out of the geographic service area;
- The entity does not, because of moral or religious objections, cover the service the member seeks;
- The member requests to be assigned to the same entity as family members;
- The member needs related services to be performed at the same time, not all related services are available within the managed care entity 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 entity and DHH is terminated;
- The member loses eligibility;
- The member is placed in a nursing facility or intermediate care facility for individuals with developmental disabilities;
- The members eligibility changes to an excluded eligibility group;
- To implement the decision of a hearing officer in an appeal proceeding by the member against the managed care entity or as ordered by a court of law; and
- Other reasons including, but not limited to:
    - Poor quality of care;
    - Lack of access to services covered under the contract; or
    - Documented lack of access to providers experienced in dealing with the member's healthcare needs.

4.4.5.6.2. Member Disenrollment Requests Wilthout Cause

A member may request for without cause under the following circumstances for disenrollment:

- 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 or GNOCHC PCMH;

- Once a year thereafter during the member's annual open enrollment period;

- Upon automatic re-enrollment under 42 CFR §438.56(g), if a temporary loss of Medicaid or GNOCHC eligibility has caused the member to miss the annual disenrollment opportunity; or

- If DHH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a)(3).

4.4.5.6.3. Managed Care Entity Requests for Member Disenrollment

The EB shall develop and implement processes to accept written requests for involuntary disenrollment. The request must be submitted utilizing the appropriate CCN Request for Member Disenrollment Request form (See Appendix H) which must include, at a minimum:

- The member's name;

- The member's Medicaid or GNOCHC ID number; and

- Detailed reasons for requesting the disenrollment which may include:

    - The member's fraudulent use of the ID card.

    - The member's behavior is disruptive, unruly, abusive, or uncooperative to the extent that enrollment seriously impairs their ability to furnish services to either the member or other members.

The EB is encouraged to develop a web-based system for use by managed care entities in submitting requests for involuntary disenrollments.

The EB, at the discretion of DHH, shall review all requests received and render a decision on a case-by-case basis.

If the disenrollment request is approved, the EB shall notify the member in writing of the action taken and give the member the opportunity to choose another managed care entity which they are eligible to participate or file a request for a state fair hearing. In all cases the managed care entity shall continue to

coordinate and provide care until the member has been disenrolled.

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.

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.

DHH, the managed care entity, and the EB shall reconcile enrollment/ disenrollment issues at the end of each month utilizing an agreed upon procedure.

4.4.6. Telephonic Information Hotline

4.4.6.1. Call Center

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

4.4.6.1.2. Based on historical call activity, the monthly call activity is approximately 35,000 – 40,000 incoming and outgoing calls.

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

4.4.6.1.4. It will be incumbent upon the EB to adjust staffing levels during the contract period based upon the anticipated volume of calls on a monthly basis, without additional negotiations or payment from DHH. This includes the transitioning approximately 900,000 existing Medicaid members from either CommunityCARE 2.0 or fee-for-service Medicaid to a CCN between November 2011 and May 2012.

4.4.6.1.5. DHH will retain the right to approve changes to the operating hours.

4.4.6.1.6. Important features of the telephone system will include but are not limited to:

a) Monitoring capabilities that allow supervisors to audit the manner in which a call is processed as well as the efficiency of the operator;

b) A TTY toll-free number for the hearing impaired as well as language interpretation services;

c) Reporting capabilities that provide such information as:

- Length of time per call;
- Number of calls waiting (or in queue);
- Number of calls abandoned;
- Number of calls per hour;
- Number of calls waiting more than two (2) minutes;
- Individual operator workload;
- Reason for the call;
- Number of calls received after hours;
- Notification when a caller has been on hold for thirty (30) seconds so that no call waits more than two (2) minutes for assistance. During the hold period the EB shall have health informational messages on the line; and
- Amount of call center downtime.
    - Automatic routing of call to the next available operator;
    - Capability of routing calls from specific sources (e.g., Members, CCNs, GNOCHC PCMHs) to a designated group of operators; and
    - Monitoring capability that allows instant determination of an operator's availability (i.e., available, on a call, completing after-work, etc.).

4.4.6.1.7. Capability for all calls to be answered promptly (within three [3] rings coming out of hold message) during normal business hours.The toll-free number shall be staffed by trained personnel who have a working knowledge of Louisiana Medicaid and GNOCHC services available.

4.4.6.1.8. Within thirty (30) days of the start of the contract, the EB shall develop a training and evaluation module for call center staff to ensure adequate knowledge of Louisiana Medicaid programs, including but not limited to the GNOCHC Program. The training module must be approved by the Department before implementation.

4.4.6.1.9. The toll-free line shall allow Members to:

a) Select a managed care entity and specify their choice of PCP (if available);

b) Request a change of managed care entity;

c) Request information about accessing services;

d) Discuss problems with the program;

e) Register complaints;

f) Request other assistance in accessing services; and

g) Notify the EB of changes (i.e. new address, phone number, etc).

4.4.6.1.10. The EB shall notify the Department within thirty (30) minutes of awareness when there is difficulty with the phone line. The EB shall have the capability to monitor the telephone lines on-line for quality control.

4.4.6.1.11. CCN Administrative Performance Measure Verification Calls

a) The call center staff shall perform a random sample of 20 calls to different PCP practices within each CCN on a monthly basis to assist DHH in validating CCN compliance with the following performance measure:

i. % of PCP Practices that provide verified 24/7 phone access with ability to speak with a PCP Practice clinician (MD, DO, NP, PA, RN, LPN) within 30 minutes of member contact.

b) The monthly results data shall be submitted to DHH in a quarterly report detailing the previous three (3) months of calls for each CCN and an annual summation report for each CCN.

4.4.6.1.12. Complaints

a) The EB must record and track Member complaints.

b) The EB must generate complaint and complaint resolution results.

c) The EB must record complaint activities.

4.4.6.2. Call Monitoring and Case Accuracy

4.4.6.2.1. To ensure excellent customer service, accuracy, consistency, and timeliness of enrollments, the EB must propose a call and case monitoring process.

4.4.6.2.2. The call and case monitoring process must include the approach, measurement objectives, monitoring frequency, sample size, result reporting, quality goals, and planned courses of action to be taken if the quality goal is not met.

4.4.6.2.3. The EB shall design and implement a comprehensive call and case monitoring process within thirty (30) days of contract award to ensure staff follows proper protocol, policies, and procedures in the handling of inbound and outbound data and interactions with the client. The comprehensive call and case monitoring process shall be submitted to DHH for approval prior to implementation.

4.4.6.2.4. The ability to record, view, and store the entire contact event including call transfers, screen shots, agent notations, etc for both local and remote contact center positions. Conversations must be retained for a period of no less than six months and be easily accessible by DHH.

4.4.7. Operations Requirements

4.4.7.1. Facility Location

4.4.7.1.1. The EB shall procure, equip, furnish, operate and maintain facilities appropriate to support the requirements of this RFP.

4.4.7.1.2. The Louisiana management location shall not be more than 15 miles from the department's main headquarters in Baton Rouge, Louisiana. The physical location of the call center (including overflow call centers) must be located within the United States.

4.4.7.1.3. DHH reserves the right to perform physical security checks of the EB's facilities at its discretion.

4.4.8. Staffing Requirements / Qualifications

4.4.8.1. Staffing

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

4.4.8.1.2. For the purposes of this contract, the EB 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 EB 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

4.4.8.1.3. The EB must employ sufficient staffing and utilize appropriate resources to achieve contractual compliance. The EB'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 EB 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 EB to hire additional staff and application of monetary penalties as specified in Section 7 of this RFP.

4.4.8.1.4. The EB 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.

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

4.4.8.1.6. DHH shall approve the hiring of all key staff.

4.4.8.1.7. Key staff may not be removed or reassigned without approval of DHH which will not be withheld if a suitable candidate is proposed.

4.4.8.1.8. 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.

4.4.8.1.9. The EB shall inform DHH in writing within seven (7) days, when an employee leaves one of the Key Staff positions listed below. The vacancy shall be filled within thirty (30) days. Staff assignments shall be fully covered at all times. The name of the interim contact person should be included with the notification. 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.

4.4.8.1.10. The EB shall replace any of the key staff with a person of equivalent experience, knowledge and talent. This notification shall take place within five (5) business days of the resignation/termination.

4.4.8.1.11. Annually, the EB 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].

4.4.8.1.12. The EB shall include at a minimum the following key staff:

a) Project Director should have at least six (6) years of experience in managing a similar project of equal or greater scope;

b) Deputy Project Director should have at least five (5) years of experience in managing a similar project of equal or geater scope.

c) Call Center Manager should have at least three (3) years experience in Member relations to supervise the toll-free telephone line operators. Sufficient qualified staff shall be hired and trained by the EB to meet the objectives and to carry out the scope or work delineated in this proposal. In addition, sufficient telephone operators and staff must be provided to support the level of effort required to comply with this RFP. Field and central office staff must be able to deal effectively with enrollees and potential enrollees.

d) All key staff must have a working knowledge of the Department, Louisiana Medicaid and LaCHIP, and the individual managed care Medicaid programs. The EB shall provide a detailed outline of the training plan and orientation package for staff.

e) The EB staff must possess sufficient Personal Computer expertise to provide for the reports and automation necessary to support the contract.

4.4.8.1.13. Complaints Regarding EB Staff

Complaints received by the EB regarding any conflict of interest or inappropriate conduct of the EB's staff must be followed by a written report of the incident to the Department within forty eight (48) hours of the reported complaint.

4.4.8.1.14. Ineligible Persons for Employment

a) The EB must ensure that all entities or individuals, whether defined as "Key Staff" or not, performing services under contract with Louisiana Medicaid are not "Ineligible Persons" to participate in the Federal health care programs or in Federal procurement or non-procurement programs or have been convicted of a criminal offense that falls within the ambit of 42 U.S.C 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible. Exclusion lists include the Department of Health and Human Services/ Office of Inspector General List of Excluded Individuals/Entities (available via the internet at http://www.oig.hhs.gov) and the General Services Administration's List of Parties Excluded from Federal Programs (available via the Internet at http://www.epls.gov).

b) All temporary, permanent, subcontract, part-time and full-time EB staff working on Louisiana Medicaid contracts must complete an annual statement that includes an acknowledgement of confidentiality requirements and a declaration as to whether the individual has been convicted of a felony crime or has been determined an "Ineligible Person" to participate in Federal Health care programs or in Federal procurement or non-procurement programs. If the individual has been convicted of a felony crime or identified as an "Ineligible Person", the EB must notify DHH in writing on the same date the notice of a conviction or ineligibility is received.

c) The EB shall keep the individual statements on file and submit a comprehensive list of all current staff in an annual statement to DHH, indicating if the staff stated they were free of convictions or ineligibility referenced above.

d) If the EB has actual notice that any temporary, permanent, subcontract, part-time, or full-time EB staff has become an "Ineligible Person" or is proposed to become ineligible based on pending charges, the EB shall remove said personnel immediately from any work related to this Contract and notify DHH within five (5) business days. For felony convictions, the Department will determine if the individual should be removed from the contract project.

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5. RECORD KEEPING REQUIREMENTS

The EB agrees to retain all books, records and other documents relevant to the contract and funds expended there under for at least four (4) years after final payment or as prescribed in 45 CFR 74:53 (b) whichever is longer. The EB shall make available to DHH such records within thirty (30) days of DHH's written request and shall deliver such records to DHH's central office in Baton Rouge, Louisiana, all without expense to the Department. The EB shall allow DHH to inspect, audit or copy records at the EB's site, without expense to DHH.

5.1. Reporting Requirements

The EB shall comply with all the reporting requirements established by this Contract. Reports to be generated by the EB shall meet all state and federal reporting requirements. The needs of DHH, and other appropriate agencies for planning, monitoring and evaluation shall be taken into account in developing report formats and compiling data.

The EB 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 EB 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 EB's duties and obligations under the Contract with DHH. Information considered to be of a proprietary nature shall be clearly identified as such by the EB 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 EB adequate time to prepare the reports.

The EB 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.

5.1.1. Ad Hoc Reports

The EB 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 EB's duties and obligations under this Contract. Information considered to be of a proprietary nature shall be clearly identified as such by the EB 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 EB adequate time to prepare the reports.

5.1.1.1. Errors

The EB agrees to prepare complete and accurate reports for submission to DHH. If after preparation and submission, an EB error is discovered either by the EB or DHH; the EB shall correct the error(s) and submit accurate reports as follows:

5.1.1.1.1. For all reports – Fifteen (15) calendar days from the date of discovery by the EB 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 EB can demonstrate to DHH's satisfaction the problem cannot be corrected within fifteen (15) calendar days.

5.1.1.1.2. Failure of the EB to respond within the above specified timeframes may result in a loss of any money due the EB and the assessment of monetary penalties as provided in Section 7 - Administrative Actions, Monetary Penalities and Sanctions Section of this RFP.

5.1.1.2. Report Submission Timeframes

5.1.1.2.1. The EB 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 contractors failure to submit the reports or files as specified may result in the assessment of monetary penalties, as stated in the Section 7 - Administrative Actions, Monetary Penalities and Sanctions of this RFP.

5.1.1.2.2. Unless otherwise specified, deadlines for submitting files and reports are as follows:

5.1.1.2.3. Daily reports and files shall be submitted within one (1) business day following the due date;

5.1.1.2.4. Weekly reports and files shall be submitted on the Wednesday following the reporting week;

5.1.1.2.5. Monthly reports and files shall be submitted within fifteen (15) calendar days of the end of each month;

5.1.1.2.6. 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;

5.1.1.2.7. Annual reports and files shall be submitted within thirty (30) calendar days following the twelfth (12th) month; and

5.1.1.2.8. Ad Hoc reports shall be submitted within three (3) business days from the agreed upon date of delivery.

5.1.1.3. Report Submissions Chart

The report submission chart contains a summarized list of reports or files to be submitted by the EB (identified as EB), DHH and the CCN. The established format and/or layout requirements for each report or file are located in the CCN Systems Companion Guides, Quality Companion Guide, Appendixes 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
EB	Organizational Chart	Annually	N/A	DHH – Coordinated Care Section
EB	Functional Organizational Chart	Annually	N/A	DHH – Coordinated Care Section
EB	Network Provider and Subcontractor Registry	Weekly and Monthly	CCN-P Systems Companion Guide	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

Submitter	Report or File Name	Frequency	Format Location	Receiver
EB	Member Linkage File	Daily	CCN- P Systems Companion Guide TBD	CCN
EB	Member Linkage File	Daily and Weekly	CCN – P Systems Companion Guide TBD	DHH – FI
EB	Administrative Performance Measure Verification Report	Quarterly	TBD	DHH – Coordinated Care Section
EB	Contract Status Report	Annually	TBD	DHH – Coordinated Care Section
EB	Enrollee Preferred Language Report	Monthly	TBD	CCN
EB	Member Services Unsuccessful new member contacts Member Services Call Center	Monthly Monthly with an Annual Summary	TBD	DHH – Coordinated Care Section
EB	Provider Call Center	Monthly with an Annual Summary	TBD	DHH – Coordinated Care Section
EB	Member Disenrollment File	Daily and Weekly	CCN-P Systems Companion Guide TBD	DHH – FI

Submitter	Report or File Name	Frequency	Format Location	Receiver
EB	Processing Errors	Daily	TBD	DHH - FI
EB	Member Reconciliation Report	Monthly	TBD	CCN
CCN	Non-Medicaid Enrolled Providers	Monthly	TBD	DHH – FI
EB	Security Issues Report	Quarterly	N/A	DHH – Coordinated Care Section
DHH – FI	Claims Historical Data File	At Implementation and Weekly thereafter	CCN-P Systems Companion Guide TBD	EB
CCN	Back-up File List	Quarterly	Systems Companion Guide TBD	DHH – Coordinated Care Section
EB	New Enrollees Survey	Quarterly	TBD	DHH – Coordinated Care Section
EB	Member Complaint Report	Monthly, and Quarterly Summary	TBD	DHH – Coordinated Care Section
EB	System Refresh Plan	Annually	Systems Companion Guide TBD	DHH - Coordinated Care Section

Submitter	Report or File Name	Frequency	Format Location	Receiver
EB	Fraud and Abuse Activity Report	Quarterly with an Annual Summary	TBD	DHH – Coordinated Care Section

5.1.1.4. Member Reports

a) EB shall submit monthly member reports to DHH with:

- Acceptors and decliners – number, location, age group
- Member contacts via Toll Free Telephone number – summary report by topic of call including Member complaints
- EB must document, track and if appropriate resolve complaints

b) Special Needs Case Management – tracking reports of all incoming call and disposition of calls from Members and Providers related to Special Needs Case Management mailed, etc.)

c) Summarization of Linkages – new linkages, auto-assignments, choices, changes including reasons for change

5.1.1.5. CCN Reports

5.1.1.5.1. CCN Linkage Report shall be submitted to DHH monthly and shall include but not be limited to:

a) Current CCNs listed by parish and region, summary by region and state;

b) Demographics – CCN name, address, phone number and Medicaid ID;

c) Provider information – CCN providers, current linkages, potential capacity, linkage restrictions; and

d) Map with regions delineated and number of CCNs per parish and mileage radius delineated.

5.1.1.5.2. Enrollee Preferred Language Report

The EB shall submit monthly to each CCN and DHH a listing of linked enrollees that includes the preferred primary language of the enrollee. The EB should include an indicator

for any language that is spoken as a primary language for 200 or more members of a CCN within a GSA.

5.1.1.5.3. Enrollees with Special Needs Report

The EB shall provide along with enrollment file the name of enrollees which have self identified as requiring special health care needs.

5.1.1.6. GNOCHC Reports

5.1.1.6.1. GNOCHC PCMH Linkage Report shall be submitted to DHH monthly containing the following:

a) Current GNOCHC PCMH listed by parish, summary by region;

b) Demographics – GNOCHC PCMH name, address, phone number and GNOCHC ID;

c) Provider information – GNOCHC PCMH providers, current linkages, linkage restrictions; and

d) Map with parishes delineated and number of GNOCHC PCMHs per parish and mileage radius delineated.

5.1.1.6.2. Enrollee Preferred Language Report

The EB shall submit monthly to each GNOCHC PCMH and DHH a listing of linked enrollees that includes the preferred primary language of the enrollee. The EB should include an indicator for any language that is spoken as a primary language for 200 or more members of a GNOCHC PCMH within a GSA.

5.1.1.7. CCN Administrative Performance Measure Verification Report

The EB shall electronically submit a quarterly Administrative Performance Measure Verification Report to DHH to include the three (3) months of calls for each CCN and an annual summation report for each CCN.

5.1.1.8. Complaint Report

The EB shall submit monthly complaint and complaint resolution reports in the format approved by DHH.

5.1.1.9. Annual Contract Status Report

The CCN shall submit a Status of Contract Responsibilities report within ninety (90) calendar days within the end of the first full contract year and each full contract year thereafter. This report will include a summarization of all monthly reports.

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6. TRANSITION PLAN

6.1. The EB shall comply with the transition plan requirements outlined in Appendix I – Transition Plan Requirements which outlines the procedures and timelines to ensure continuity of services in the event of contract termination or award of contract to another vendor. The takeover/ transition plan requires the EB, at a minimum, to comply with the following stipulations:

6.1.1. Upon completion of this contract or if terminated earlier, all records, reports, work sheets or any other pertinent materials related to the execution of this contract shall become the property of DHH;

6.1.2. In the event of contract termination, or as requested, the EB shall transfer all data and non-proprietary systems to the Department or new vendor within the agreed upon time frame;

6.1.3. Upon termination of contracted services, all equipment purchased under this agreement shall revert to the State. The EB agrees to deliver any such equipment to the State within the pre-determined time frame.

6.1.4. The takeover/transition plans must be adhered to within 30 calendar days of written notification of contract termination, unless other appropriate time frames have been mutually agreed upon by both the EB and the Department.

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7. ADMINISTRATIVE ACTIONS, MONETARY PENALITES & SANCTIONS

7.1. DHH Administrative Actions

7.1.1. DHH shall notify the EB 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 and termination and include, but are not limited to:

7.1.1.1. A warning through written notice or consultation;

7.1.1.2. Education requirement regarding program policies and procedures;

7.1.1.3. Referral to the appropriate authority for fraud investigation; and/or

7.1.1.4. Require submission of a corrective action plan.

7.2. DHH Monetary Pentalties

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.

7.2.1. In the event the EB fails to meet the performance standards specified within the contract, the monetary penalties defined below may be assessed.

7.2.2. The decision to impose monetary penalties shall include consideration of some or all of the following factors:

7.2.2.1. The duration of the violation;

7.2.2.2. Whether the violation (or one that is substantially similar) has previously occurred;

7.2.2.3. The EB's history of compliance;

7.2.2.4. The severity of the violation and/or whether it imposes an immediate threat to the health or safety of the Medicaid recipient(s); and

7.2.2.5. The "good faith" exercised by the EB in attempting to stay in compliance.

TABLE OF MONETARY PENALTIES	
FAILED DELIVERABLE	**SANCTION**
Reports – Late submission of required reports	$1000.00 per business day, per report
Key Staff – Failure to fill vacant contractually required key staff positions within 30 days after the 31st day with an employee approved by DHH	$500.00 per business day
File Updates – Failure to maintain all files and perform all file updates according to the requirements in the Contract after agreed upon date.	$500.00 per business day for each day after the agreed upon date.
Call Center – Failure to comply with call center requirements as specified in the RFP or as agreed to by the Department.	$500.00 per occurrence
EB Requirements – Failure to comply with EB Requirements as specified in the Contract	$1500 per business day, per deliverable.
Operations – Failure to get operations back up and running within 72 hours in the event of an emergency.	$100.00 per hour for every hour or part of an hour.
Disaster / Emergency Event – Failure to get call center operations back on line following a disaster or emergency event.	$100.00 per hour for every hour or part of an hour.
Emergency Management Plan – Failure to submit the Plan as specified in this RFP and the plan is received after the due date or up to ten thousand dollars ($10,000) for failure to submit timely. However DHH may assess an additional ten thousand dollars ($10,000) for failure to submit the plan prior to the beginning of the Atlantic hurricane season (June 1st).	Two thousand dollars ($2,000.00) per calendar day

TABLE OF MONETARY PENALTIES	
Choice Counseling – CCN Initial Enrollment Failure to meet DHH's goal of 51% member pro-active selection of CCN.	$200,000 – Failure to meet the member proactive selection goal of 51% during Phase 1 of implementation of the CCN Program. $200,000 – Failure to meet the member proactive selection goal of 51% during Phase 2 of implementation of the CCN Program . $200,000 – Failure to meet the member proactive selection goal of 51% during Phase 3 of implementation of the CCN Program.
Choice Counseling – CCN Initial Enrollment Failure to meet DHH's goal of less than 51% member pro-active selection of CCN on an annual basis for contract year 2 and subsequent contract years. (Contract year is defined as August 1st through July 31st.)	$200,000 – Failure to meet the member proactive selection goal of 51%
Termination /Transition Plan – Failure to submit the plan six months prior to the end of the contract period or any extension thereof or if earlier, within thirty (30) days of Notice of Termination.	One thousand dollars ($1,000.00) per calendar day the plan is late, inaccurate, or incomplete.
Ad Hoc Reports.- As required by this Contract or upon request by DHH and mutually agreed upon by the EB.	One thousand dollars ($1,000.00) per calendar day for each business day that a report is late or incorrect.
Violation of §7.5.1	Up to $10,000 per occurrence

7.3. DHH Monetary Penalties for Noncompliance with Other Timely Reporting or Deliverable Requirements

7.3.1. For each day that a deliverable is late, incorrect or deficient, the EB 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.

7.3.2. 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
1-6	$ 750	$ 1,200	$ 2,000	$ 3,000
7-11	$ 1,000	$ 1,500	$ 3,000	$ 5,000
12 – and beyond	$ 1,500	$ 2,000	$ 4,000	$ 6,000

7.4. Penalties for Failure to Comply with Member Education Requirements

7.4.1. Whenever DHH determines that the EB, its agents, subcontractors, volunteers or providers have engaged in any unfair, deceptive, or prohibited member education practices in connection with enrolling members in a CCN, one or more of the remedial actions listed below shall apply.

7.4.1.1. DHH shall notify the EB 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 EB must perform;

7.4.1.2. DHH may require the EB to recall the previously authorized member education material(s);

7.4.1.3. DHH may deduct the amount of enrollment fee for members enrolled as a result of non-compliant education practices from the next monthly payment made to the EB and shall continue to deduct such payment until correction of the failure; or

7.4.1.4. DHH may require the EB to contact each member who enrolled during the period while the EB 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.

7.5. Other Monetary Sanctions

7.5.1. DHH shall notify the EB 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 EB to employ the dispute resolution process as described in this RFP. The following are non-exhaustive grounds for which sanctions may be imposed when a EB acts or fails to act. The EB:

7.5.1.1. Acts to discriminate among members on the basis of their health status or need for health care services 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.

7.5.1.2. Misrepresents or falsifies information that it furnishes to DHH;

7.5.1.3. Misrepresents or falsifies information that it furnishes to a member, potential member, or a health care provider;

7.5.1.4. Distributes directly, or indirectly through any agent or independent contractor, member materials that have not been approved by DHH or that contain false or materially misleading information; or

7.5.1.5. Violates any of the other applicable requirements of sections 1903(m), 1905(t)(3) or 1932 of the Social Security Act and any implementing regulations.

7.5.2. The following factors will be considered in determining sanction(s) to be imposed:

7.5.2.1. Seriousness of the offense(s);

7.5.2.2. Failure to perform administrative functions;

7.5.2.3. Extent of violations; history of prior violations; prior imposition of sanctions;

7.5.2.4. Prior provision of EB education; EB willingness to obey program rules; and

7.5.2.5. Whether a lesser sanction will be sufficient to remedy the problem.

7.6. Misconduct for Which Sanctions May Be Imposed

7.6.1. DHH may impose sanctions against the EB if the agency finds any of the following non-exclusive actions/occurrences:

7.6.1.1. The EB has failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from DHH;

7.6.1.2. The EB, 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;

7.6.1.3. The EB has presented, or has caused to be presented, any false or fraudulent data or has submitted or has caused to be submitted false information to be furnished to the State or the Secretary of federal Department of Health and Human Services;

7.6.1.4. The EB has accepted a fee or portion of fee or charge for a member enrollment to a CCN;

7.6.1.5. The EB knowingly has failed to identify overpayments or otherwise erroneous payments from DHH;

7.6.1.6. The EB has failed to keep or make available for inspection, audit or copying, such records regarding payments claimed for providing services;

7.6.1.7. The EB has failed to furnish any information requested by DHH regarding payments for providing goods or services;

7.6.1.8. The EB has made, or caused to be made, any false statement or representation of a material fact to DHH or CMS in connection with the administration of the contract; and

7.6.2. DHH may require a corrective action plan to be developed and approved by DHH in situations where sanctions may be imposed. DHH shall approve and monitor implementation of such a plan and set appropriate timelines to bring activities of the EB 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 sanctions, DHH shall give the EB timely written notice that explains the basis and nature of the sanction and any other due process protections that DHH elects to provide.

7.7. Payment of Monetary Penalties

7.7.1. 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 EB's receipt of the notice of monetary penalties. However, in the event an appeal by the EB results in a decision in favor of the EB, any such funds withheld by DHH will be returned to the EB.

7.7.2. If monetary penalties are insufficient, DHH has the right to pursue actual damages. If the EB's failure to perform satisfactorily exposes DHH to the likelihood of contracting with another person or entity to perform services

required of the EB under this contract, upon notice setting forth the services and retainage, DHH may withhold from the EB payments in an amount commensurate with the costs anticipated to be incurred. DHH shall account to the EB and return any excess to the EB. If retainage is not sufficient, the EB shall immediately reimburse EB the difference or DHH may offset from any payments due the EB. The EB will cooperate fully with DHH and provide any assistance it needs to implement the terms of its agreement for services for retainage.

7.7.3. DHH has the right to recovery of any amounts overpaid as the result of deceptive practices by the EB and/or its subcontractors, and may consider trebled damages, civil penalties, and/or other remedial measures.

7.7.4. A monetary sanction may be applied to all known affiliates, subsidiaries and parents of a EB, 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 EB 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.

7.8. Corrective Action

Whenever monetary penalties for a single occurrence exceed $2,000.00, DHH staff will meet with EB 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 EB, 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.

7.9. 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. DHH may terminate the contract as a sanction and if DHH, at its sole discretion, determines that the EB has failed to carry out the substantive terms of the Contract or 2) meet applicable requirements in section 1903 of the Social Security Act.

7.10. Termination for Cause

7.10.1. DHH may terminate the Contract when DHH determines the EB and/or EB subcontractor(s) have failed to perform, or have violated, substantive terms of the Contract and have failed to meet federal or state requirements.

7.10.2. DHH will provide the EB with a timely written Notice of Intent to Terminate (Notice). 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.

7.10.3. The termination will be effective no less than thirty (30) calendar days from the date of the Notice. The EB 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.

7.10.4. DHH will conduct a pre-termination hearing upon the request of the EB as outlined in the Notice to provide EB the opportunity to contest the nature and basis of the sanction. The EB may request a pre-termination hearing with the Medicaid Director and/or a dispute resolution conference before the DHH Undersecretary prior to the determined date of termination stated in the Notice.

7.10.5. The EB shall receive a written notice of the outcome of the pre-termination hearing and/or dispute resolution conference, indicating decision reversal or affirmation.

7.10.6. 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.

7.11. Termination for Ownership Violations

The EB is subject to termination, unless the EB can demonstrate changes of ownership or control, when:

7.11.1. A person with a direct or indirect ownership interest in the EB:

7.11.1.1. Has been convicted of a criminal offense under §§1128(a) and 1128(b)(1);

7.11.1.2. Has had civil monetary penalties or assessment imposed under § 1128A of the Social Security Act; or

7.11.1.3. Has been excluded from participation in Medicare or any State health care program.

7.12. Transition Requirements

The EB shall comply with all requirements specified in Transition Requirements. The turnover requirements in Section are applicable upon any termination of the Contract when:

7.12.1. Initiated by the CCN as allowed in this RFP;

7.12.2. Initiated by DHH, or

7.12.3. At the end of the contract period.

8. FRAUD AND ABUSE

8.1. The EB shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities.

8.2. Such policies and procedures must be in accordance with state and federal regulations. EB shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the EB in preventing and detecting potential fraud and abuse activities.

8.3. To promote integrity in EB functions, the EB must design a proactive fraud prevention, detection, and referral process which guards against internal (staff) and external (clients or others) fraud, abuse, or waste of benefits and misuse of the systems that support the EB.

8.4. The process must enhance the prevention and detection of internal and external fraud.

8.5. The process must also include a referral process to the DHH Office of Inspector General, in compliance with Federal and State requirements and as approved by the Inspector General.

8.6. The EB must utilize data processing techniques to enhance potential fraud identification.

8.7. When cases of suspected fraud or abuse are identified, the EB must refer them to Office of the Inspector General, within timeframes and procedures approved by the Inspector General.

8.8. Once a referral is made to the Office of the Inspector General, the EB must make staff and resources available to Inspector General Staff, as required by the investigation.

8.9. The EB must establish effective processes, systems, edits, and controls to prevent and detect internal and external fraud, abuse, or waste.

8.10. The State may supplement at their option the EB's fraud detection and/or reduction efforts, and will require the EB to take reasonable steps to coordinate with the State's and Federal efforts.

8.11. The EB must:

8.1.1. Develop a fraud, abuse, and waste prevention compliance plan that establishes criteria for preventing, detecting, and referring cases of suspected fraud, abuse, or waste.

8.1.2. Create processes to investigate suspected fraud, abuse, and waste that do not infringe on the rights of individuals and are consistent with due process of law.

8.1.3. Designate a key EB official as compliance officer for the EB who is responsible for making the decisions on cases to refer to the State.

8.1.4. Maintain appropriate records for a period of 7 years or until the end of the contract term. Deliver the records to the State at the end of the contract term and/or make these records available to the DHH Office of Inspector General (OIG), Office of Attorney General (OAG) or general counsel upon request.

8.1.5. Refer all cases of suspected fraud, abuse, or waste to the Office of Inspector General within the timeframes and in the formats specified by the Inspector General.

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9. TECHNICAL REQUIREMENTS

9.1. General Responsibilities

9.1.1. The EB shall maintain an automated enrollment management system which is capable of accepting recipient claims data, verifying eligibility, collecting and reporting enrollee choices, and validating files from DHH's FI and manage care entity. The EB shall ensure that its System meets the requirement of this RFP, and all applicable state and federal laws, rules and regulations, including Medicaid confidentiality and HIPAA and American Recovery and Reinvestment Act (ARRA) privacy and security requirements.

9.1.2. All the EB's applications, operating software, middleware, and networking hardware and software shall be able to interoperate as needed with DHH's FI systems and shall conform to applicable standards and specifications set by DHH.

9.1.3. The EB'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.

9.1.4. The EB shall be responsible for all initial and recurring costs required for access to DHH system(s), access to the Fiscal Intermediary, access to managed care entity, as well as DHH access to the EB's system(s). These costs include, but are not limited to, hardware, software, licensing, authority/permission to utilize any patents, annual maintenance, support, and connectivity with DHH, the Fiscal Intermediary (FI), the managed care entity and its trading partners.

9.1.5. The EB shall identify in their proposal all systems which are considered to be proprietary.

9.1.6. The EB shall have the capability to securely transfer or exchange data with DHH, in the requested formats, within the timelines approved by DHH and as specified in this RFP. The EB shall have the capability to interface with existing and future systems, such as the planned implementation of a new Fiscal Intermediary.

9.1.7. The EB shall comply with Section 508 of the Rehabilitation Act of 1973 with regard to any websites exposed to the public. DHH will maintain ownership rights to all Internet registered domains for all websites exposed to the public.

9.1.8. The EB shall produce and maintain a CCN / PCP Geo Coding denoting if the practice is open or closed, name(s) of practitioners at the site (if practice is a group) address and phone numbers.

9.1.9. The EB shall have a email blast capacity that will compile and maintain a list of PCP email addresses and have the ability to email PCP's individually as needed as well as sending "blast" e-mails to all PCP's as a group.

9.1.10. The EB shall provide an outline and flow chart(s) which describes how their proposed solution will meet or advance the Medicaid Information Technology Architecture (MITA) maturity level of the business processes pertaining to this RFP.

9.1.11. The EB shall provide online documentation of the system(s) to be delivered upon implementation, within thirty (30) days of a major change, or as requested by DHH;

9.1.12. The EB shall ensure the system(s) will be available twenty-four (24) hours a day, seven (7) days a week. Maintenance and down time shall be scheduled and approved by DHH. All unscheduled downtime must be reported to DHH immediately, with stated corrective action and workarounds; and

9.1.13. The EB shall provide DHH staff with real time access to the system(s) and shall incur all of the related costs.

9.1.14. The EB is encouraged to propose innovative and efficient skill sets, tools and techniques to provide services included in this RFP.

9.1.15. The EB's response shall include a detailed description of its proposed solution to support EB System functionality.

9.1.16. The EB must maintain hardware and software compatible with current DHH requirements which are as follows:

9.1.16.1. 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; and
- 1 gigabyte Ethernet card.
- Enough spare USB ports to accommodate thumb drives, etc.
- Printer compatible with hardware and software required.

9.1.16.2. 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;

9.1.16.3. Additional Workstation Requirements

- Each workstation should have access to high speed Internet.

- A desktop compression/encryption application that is compatible with WinZIP v11.0;

- Each workstation connected to the Internet should have anti-virus, anti-spam, and anti-malware software. Regular and frequent updates of the virus definitions and security parameters of these software applications should be established and administered;

- 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.).

9.1.16.4. Connectivity

9.1.16.4.1. The EB shall establish connectivity with DHH, DHH's Fiscal Intermediary, the CCN and other trading partners as necessary. The EB must have capacity for real time connectivity to all DHH approved systems.

9.1.16.4.2. It is the responsibility of the EB to ensure that bandwidth is sufficient to meet the performance requirements of this RFP.

9.1.16.4.3. The EB shall maintain daily working interfaces with DHH, DHH's Fiscal Intermediary, the CCN and other trading partners as necessary.

9.1.16.4.4. The EB shall provide access to a secure File Transfer Protocol (FTP) server at the EB's location at the EB's expense.

9.1.16.4.5. DHH and DHH's Fiscal Intermediary shall be provided with a non-expiring login id and password to the FTP server by the EB.

9.1.16.4.6. The EB shall maintain the FTP server and allow space to store all files to be sent to the EB's location.

9.1.16.4.7. 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 EB is expressly prohibited from sharing or publishing DHH's information and reports without the prior written consent of DHH. In the event a dispute regarding the sharing or publishing of information and reports, DHH's decision on this matter shall be final.

9.1.16.5. Testing

The EB shall provide proof of data transfer capabilities verified in writing by DHH and its Fiscal Intermediary. Proof shall constitute the successful transfer of test files via EDI and meet DHH file format requirements.

9.1.16.6. Accessibility

9.1.16.6.1. The EB shall ensure that the enrollment process is accessible to eligible Medicaid potential enrollees and enrollees by mail, internet, and toll-free telephone.

9.1.16.6.2. The EB must provide and maintain an internet website to support the requirements of this RFP.

9.1.17. Electronic File Transfers

9.1.17.1. The EB shall send and receive transactions, in formats and methods specified by DHH, to and from:

9.1.17.1.1. DHH's FI and its trading partners at times and locations determined by DHH;

9.1.17.1.2. DHH and its trading partners at times and locations determined by DHH; and

9.1.17.1.3. Each CCN or GNOCHC PCMH and its trading partners at times and locations determined by DHH.

9.1.17.2. All files must be in compliance with HIPAA rules and regulations.

9.1.17.3. The EB shall receive and investigate any discrepancies on the transmission of a managed care entity file.

9.1.18. Network Provider and Subcontractor Registry

9.1.18.1. The EB shall be able to receive, store and display an electronic version of the Network Provider and Subcontractor Registry of each CCN.

9.1.18.2. The EB will maintain and update weekly an electronic CCN Network Provider and Subcontractor Registry of each CCN that is accessible through the internet.

9.1.18.3. The EB shall receive, store and update the Network Provider and Subcontractor Registry of each CCN weekly from DHH's Fiscal Intermediary.

9.1.18.4. Provider

9.1.18.4.1. The EB shall receive, store, process and update provider and provider site files daily, weekly, and at other times requested by DHH, from DHH's FI.

9.1.18.4.2. The EB will update their Provider file with the same provider type, provider specialty and provider sub-specialty codes as those used by DHH.

9.1.18.4.3. The EB shall send daily provider information to each CCN which shall also include those providers no longer enrolled in Medicaid and those providers newly enrolled in Medicaid.

9.1.18.4.4. The EB shall accept and record CCN identifying codes and National Provider Identifiers (NPI).

9.1.18.4.5. The EB shall receive, store, track, crosswalk, and send National Provider Identifiers (NPI) and current format local provider identifiers until otherwise directed by DHH.

9.1.18.5. CCN Linkage and Primary Care Physician Linkage

The EB shall:

9.1.18.5.1. Send a daily file to DHH's Fiscal Intermediary for processing of CCN enrollees to create linkages to a CCN and remove linkages to a CCN;

9.1.18.5.2. Include the name of the Primary Care Physician (PCP) that the CCN enrollee is linked to, if available;

9.1.18.5.3. The EB will receive a daily file from DHH's Fiscal Intermediary on create linkages and remove linkages that could not occur on the MMIS Recipient File.

9.1.18.5.4. The EB shall send the name of the PCP requested by any enrollee to the appropriate CCN

9.1.18.5.5. From the EB's database, the EB shall be able to electronically access and identify available PCPs for member linkage.

9.1.18.5.6. The EB shall record plan selection and changes.

9.1.18.5.7. In conjunction with DHH cutoff dates, weekly and at the end of each month, the EB shall reconcile members linked to each CCN with the MMIS Recipient file.

9.1.18.6. GNOCHC PCMH Linkage

The EB shall:

9.1.18.6.1. Send a daily file to DHH's Fiscal Intermediary for processing of GNOCHC enrollees to create linkages to a GNOCHC PCMH and remove linkages to a GNOCHC PCMH;

9.1.18.6.2. The EB will receive a daily file from DHH's Fiscal Intermediary on create linkages and remove linkages that could not occur on the MMIS Recipient File.

9.1.18.6.3. The EB shall record plan selection and changes.

9.1.18.6.4. In conjunction with DHH cutoff dates, weekly and at the end of each month, the EB shall reconcile members linked to each GNOCHC PCMH with the MMIS Recipient file.

9.1.18.7. Enrollment/Recipient

The EB shall:

9.1.18.7.1. Receive, process, store and update recipient files daily, weekly, monthly and at other times requested by DHH, from DHH's Fiscal Intermediary;

9.1.18.7.2. Daily, the EB shall maintain synchronization with the MMIS recipient file;

9.1.18.7.3. Send a weekly CCN member full listing to each CCN for reconciliation and a weekly GNOCHC member full listing to each GNOCHC PCMH for reconciliation;

9.1.18.7.4. In conjunction with DHH and the CCN and GNOCHC PCMH, reconcile enrollment/disenrollment issues weekly and at the end of each month (in conjunction with DHH cutoff dates) utilizing an agreed upon procedure;

9.1.18.7.5. Monthly, the EB shall make available to DHH a listing of current CCN and a listing of current GNOCHC PCMH members to coincide with the DHH eligibility monthly cut-off, via electronic media;

9.1.18.7.6. Process approved disenrollment requests at the direction of DHH;

9.1.18.7.7. Send each CCN and GNOCHC PCMH a daily, weekly, and at other times requested by DHH, recipient file in the format specified by DHH;

9.1.18.7.8. Identify and report address changes and all other demographic data changes to DHH and/or DHH's Fiscal Agent daily;

9.1.18.7.9. Send, receive, process, report, and store enrollments and recipient data;

9.1.18.7.10. Send enrollment files daily, weekly, monthly, and as otherwise specified by DHH to each CCN and GNOCHC PCMH and DHH's Fiscal Intermediary;

9.1.18.7.11. Update its recipient and enrollment databases within twenty-four (24) hours of receipt of said file;

9.1.18.7.12. Make available to each CCN and GNOCHC PCMH, via a daily and weekly 834 X12 HIPAA compliant transaction, updates on members newly enrolled, disenrolled or with demographic changes. At the end of each week, the EB shall reconcile enrollment/disenrollment with a full 834 X12 HIPAA compliant reconciliation file;

9.1.18.7.13. Maintain and cross-reference all client related information with unique identifying data (i.e., ID #, SSN);

9.1.18.7.14. Translate enrollment data to meet HIPAA standards and requirements;

9.1.18.7.15. Have the capability to search records by a variety of fields (e.g., name, unique identification numbers, date of birth, etc.) for enrollment verification purposes;

9.1.18.7.16. Accept, record and store CCN and GNOHCH PCMH choices and CCN and GNOCHC PCMH changes for clients;

9.1.18.7.17. Maintain enrollment history segments for each appropriate program including primary care provider and CCN and GNOCHC PCMH selections;

9.1.18.7.18. Create special population indicators upon DHH's request;

9.1.18.7.19. Maintain history of any special population indicators that are requested.

9.1.18.7.20. Establish a process to handle merge and separate records;

9.1.18.7.21. Update and send to the appropriate CCN and to DHH's Fiscal Intermediary, create linkages and remove linkages of a CCN enrollee to a CCN on a daily basis;

9.1.18.7.22. Update and send to the appropriate GNOCHC PCMH and to DHH's Fiscal Intermediary, create linkages and remove linkages of a GNOCHC enrollee to a GNOCHC PCMH on a daily basis; and

9.1.18.7.23. Daily, the EB shall review the recipient information sent from DHH's FI and identify the following:

- Individuals who are required to enroll in a CCN or GNOCHC PCMH; and
- Individuals deemed ineligible for a CCN.

9.1.18.8. Claims

9.1.18.8.1. Weekly and at other times requested by DHH, the EB shall receive, process, store and update claims files from DHH's Fiscal Intermediary.

9.1.18.8.2. The EB shall maintain claims history data from the FI's claims history file to support default processing for enrollees as required by DHH.

9.1.18.9. Auto-Assignment

9.1.18.9.1. Potential enrollees/enrollees that fail to select a CCN or GNOCHC PCMH within 30 days shall be automatically assigned to a CCN/GNOCHC PCMH by the EB in accordance with DHH's approved algorithm/formula;

9.1.18.9.2. Auto assignment information must be sent to DHH's FI daily by the EB in DHH defined file formats'

9.1.18.9.3. The EB shall assign GNOCHC PCMH if the enrollee fails to make a selection within the choice period, if appropriate; and

9.1.18.9.4. The EB shall validate provider active status against the Medicaid Master Provider file prior to any GNOCHC PCMH assignment.

9.2. Management Information System

The EB shall:

9.2.1. Implement and maintain an automated Management Information System (MIS) that supports all functions of the EB process;

9.2.2. Develop a system that meets all applicable State and Federal laws, rules, and regulations (i.e. HIPAA);

9.2.3. Be capable of uniquely identifying (i.e., Master Patient Index) a distinct Medicaid member across multiple populations and Systems within its span of control;

9.2.4. 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;

9.2.5. Document and store recipient, enrollment, and other supporting EB data and maintain electronic audit trails throughout'

9.2.6. Receive interface file(s) with potential enrollees for enrollment;

9.2.7. Receive and process interface files with health care information;

9.2.8. Receive and process interface files with targeted mailing lists information and change CCN or GNOCHC PCMH choices as requested by the enrollee/potential enrollee;

9.2.9. Notify each individual CCN or GNOCHC PCMH of enrollments, and the enrollee's PCP selection, if applicable;

9.2.10. Maintain updated provider information as updated files are received from the GNOCHC PCMH, the CCN or its trading partner, DHH's FI or DHH;

9.2.11. Return provider reconciliation file to the CCN or GNOCHC PCMH;

9.2.12. Maintain a subsystem that stores and updates TPL information, capture client TPL data and notify the Fiscal Intermediary and CCN or GNOCHC PCMH of new TPL information;

9.2.13. Generate activity, balancing and error reports as defined by DHH and as requested by DHH;

9.2.14. Establish an automated process for notifying DHH of member address changes;

9.2.15. Maintain a system operational environment that ensures that the CCN and GNOCHC Programs operate according to Federal and State regulations, The requirements include but are not limited to the following requirements:

9.2.15.1. Accurate, complete, and timely system processing;

9.2.15.2. Availability to systems applications and telecommunications during hours specified by DHH;

9.2.15.3. Fully test system changes prior to inclusion in the production environment;

9.2.15.4. Coordinate external testing with agencies if deemed appropriate by DHH;

9.2.15.5. Establishment and adherence to fail-safe back-up and recovery procedures; and

9.2.15.6. Demonstrated readiness to re-establish a production environment in the event of a disaster;

9.2.16. Develop and maintain a system for comprehensive reporting to provide timely and accurate information on enrollment, disenrollment, CCN and GNOCHC changes, provider changes, and any other EB function;

9.2.17. Perform and test interfaces with the various interface partners as system changes are planned. Once system changes are implemented, post production monitoring shall occur for a period of time specified by DHH;

9.2.18. Implement approved changes and additions to the system based on Business Rules and/or Policies in accordance with the agreed upon schedule;

9.2.19. Develop a system with the capability and capacity of capturing and utilizing various data elements to develop information for Enrollment;

9.2.20. Provide a system to allow input, update, and edit of data through manual and electronic transmissions;

9.2.21. Identify and process exceptions as defined by DHH (i.e., voluntary members, exemption reason codes, DHH requested disenrollments, etc.);

9.2.22. Receive and process transactions to merge and separate records as defined by DHH;

9.2.23. Maintain a complete history of enrollments, outreach and informing activities, complaints, telephone contacts with clients and CCNs and GNOCHC PCMHs, correspondence and enrollment materials sent and/or received;

9.2.24. Update data (i.e., client data, provider data, etc.) received from DHH and the various interfaces;

9.2.25. Detect, track, monitor, and report on processing errors as a result of daily processing;

9.2.26. Implement and maintain an automated system for tracking and reporting written and telephone inquiries, and other business operations to ensure on-line retrieval of information (i.e., enrollee/potential enrollee, CCN, or GNOCHC PCMH, provider, ID number, enrollment information, etc.);

9.2.27. Create and maintain a web application that will allow CCN enrollees to select a CCN and a PCP who is a participating provider in the CCN selected and that will allow GNOCHC enrollees to select a GNOCHC PCMH; and

9.2.28. Ensures that all data systems are kept up-to-date, accurate and accessible to DHH and/or its agents for inspection, upon request.

9.3. System Availability

The EB shall:

9.3.1. Ensure that critical member and provider Internet and/or telephone-based 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 EB. Unavailability caused by events outside of the EB's span of control is outside of the scope of this requirement;

9.3.2. Ensure that at a minimum all other System functions and information are available to the applicable system users between the hours of 7a.m. and 7p.m., CDT, Monday through Friday;

9.3.3. Ensure that the systems and processes within its span of control associated with its data exchanges with DHH's Fiscal Intermediary, DHH and/or CCNs are available and operational;

9.3.4. Ensure that in the event of a declared major failure or disaster, the EB's core eligibility/enrollment system shall be back on line within seventy-two (72) hours of the failure's or disaster's occurrence;

9.3.5. Notify applicable DHH staff via phone, fax and/or electronic mail within sixty (60) minutes upon discovery of a problem within or outside the EB's span of control that may jeopardize or is jeopardizing availability and performance of critical systems functions and the availability of critical information, including any problems impacting scheduled exchanges of data between the EB and DHH's FI or the EB and a CCN or GNOCHC PCMH. In its notification, the EB shall explain in detail the impact to critical path processes such as enrollment management processes;

9.3.6. Notify applicable DHH staff via phone, fax, and/or electronic mail within fifteen (15) minutes upon discovery of a problem that results in delays in report distribution or problems in on-line access to critical systems functions and information during a business day, in order for the applicable work activities to be rescheduled or handled based on System unavailability protocol;

9.3.7. Provide information on System unavailability events, as well as status updates on problem resolution, to appropriate DHH staff. At a minimum these updates shall be provided on an hourly basis and made available via phone and/or electronic mail;

9.3.8. Resolve and implement system restoration within sixty (60) minutes of official declaration of unscheduled System unavailability of critical functions caused by the failure of system and telecommunications technologies within the EB's span of control. Unscheduled System unavailability to all other System functions caused by system and telecommunications technologies within the EB's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of System unavailability;

9.3.9. Ensure that cumulative Systems unavailability caused by systems and/or IS infrastructure technologies within the EB's span of control shall not exceed twelve (12) hours during any continuous twenty (20) business day period;

9.3.10. Within five (5) business days of the occurrence of a problem with system availability, shall provide DHH with full written documentation that includes a corrective action plan describing how the EB will prevent the problem from reoccurring; and

9.3.11. Not be responsible for the availability and performance of systems and IS infrastructure technologies outside of the EB's span of control.

9.4. Contingency Plan

9.4.1. The EB, 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;

9.4.2. Contingency plans include a disaster recovery plan (DRP) and a business continuity plan (BCP). A DRP is designed to recover systems, networks, workstations, applications, etc. in the event of a disaster. A BCP shall focus on restoring the operational function of the organization in the event of a disaster and includes items related to IT, as well as operational items such as employee notification processes and the procurement of office supplies needed to do business in the emergency mode operation environment. The practice of including both the DRP and the BCP in the contingency planning process is a best practice.

9.4.3. Minimum requirements of the Contingency Plan are defined below.

9.4.3.1. At a minimum, the Contingency Plan shall address the following scenarios:

9.4.3.1.1. The central computer installation and resident software are destroyed or damaged;

9.4.3.1.2. The system interruption or failure resulting from network, operating hardware, software, or operations errors that compromise the integrity of transactions that are active in a live system at the time of the outage;

9.4.3.1.3. 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; and

9.4.3.1.4. 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.

9.4.3.2. The Plan shall specify projected recovery times and data loss for mission-critical Systems in the event of a declared disaster.

9.4.3.3. The EB shall annually test its plan through simulated disasters and lower level failures in order to demonstrate to DHH that it can restore Systems functions.

9.4.3.4. In the event the EB fails to demonstrate through these tests that it can restore Systems functions, the EB 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.

9.5. Off Site Storage and Remote Back-up

9.5.1. The EB shall provide for off-site storage and a remote back-up of operating instructions, procedures, reference files, system documentation, and operational files.

9.5.1.1. The data back-up policy and procedures shall include, but not be limited to:

9.5.1.1.1. Descriptions of the controls for back-up processing, including how frequently back-ups occur;

9.5.1.1.2. Documented back-up procedures;

9.5.1.1.3. The location of data that has been backed up (off-site and on-site, as applicable);

9.5.1.1.4. Identification and description of what is being backed up as part of the back-up plan; and

9.5.1.1.5. Any change in back-up procedures in relation to the EB's technology changes.

9.5.1.2. 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.

9.6. System User and Technical Support Requirements

The EB shall provide Systems Help Desk services to DHH, its Fiscal Intermediary, CCN staff and any trading partners.

9.6.1. The Systems Help Desk shall:

9.6.1.1. Be available via local and toll-free telephone service, and via e-mail from 7a.m. to 7p.m., Central Time, Monday through Friday, with the exception of DHH designated holidays. Upon request by DHH and 36 hours advance notice, the EB shall be required to staff the Systems Help Desk on a state holiday, Saturday, or Sunday;

9.6.1.2. Answer questions regarding the EB'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;

9.6.1.3. Ensure individuals who place calls after hours have the option to leave a message. The EB's staff shall respond to messages left between the hours of 7:00 p.m. and 7:00 a.m. by noon that next business day;

9.6.1.4. Ensure recurring problems not specific to Systems unavailability identified by the Systems Help Desk shall be documented and reported to the EB's management within one (1) business day of recognition so that deficiencies are promptly corrected; and

9.6.1.5. Have an IS service management system that provides an automated method to record, track and report all questions and/or problems reported to the Systems Help Desk.

9.7. System Testing and Change Management Requirements

9.7.1. The EB 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:

9.7.1.1. Major changes, upgrades, modifications or updates to application or operating software associated with the following core production Systems:

- Eligibility and enrollment processing;
- Provider and data management;
- Encounter/Claims data management; and
- Conversions of core transaction management Systems.

9.7.2. The EB shall respond to DHH notification of System problems not resulting in System unavailability according to the following timeframes:

9.7.2.1. Within five (5) calendar days of receiving notification from DHH, the EB shall respond in writing to notices of system problems.

9.7.2.2. Within fifteen (15) calendar days, the correction shall be made or a requirements analysis and specifications document will be due.

9.7.2.3. The EB shall correct the deficiency by an effective date to be determined by DHH.

9.7.2.4. The EB's Systems shall have a system-inherent mechanism for recording any change to a software module or subsystem.

9.7.2.5. The EB shall put in place procedures and measures for safeguarding against unauthorized modification to the EB's Systems.

9.8. Valid Timeframe for System Changes

Unless otherwise agreed to in advance by DHH as part of the activities described above, the EB 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.

9.9. Testing

The EB 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 Fiscal Intermediary of the EB's System.

9.10. Information Systems Documentation Requirements

The EB shall:

9.10.1. 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;

9.10.2. Develop, prepare, print, maintain, produce, and distribute to DHH distinct Systems design and management manuals, user manuals and quick reference Guides, and any updates;

9.10.3. Ensure the Systems user manuals contain information about, and instruction for, using applicable Systems functions and accessing applicable system data;

9.10.4. Ensure when a System change is subject to DHH prior written approval, the EB will submit revision to the appropriate manuals before implementing said Systems changes;

9.10.5. Ensure all aforementioned manuals and reference Guides are available in printed form and on-line; and

9.10.6. Update the electronic version of these manuals immediately, and update printed versions within ten (10) business days of the update taking effect.

9.11. Systems Function Reporting Requirements

The EB shall provide systems-based capabilities, such as ad hoc tools, that enable designated DHH or Fiscal Intermediary staff, and designated Louisiana Attorney General Office staff, on a secure and read-only basis, query access to data that can be used in ad hoc reports.

9.12. Electronic Messaging

The EB shall provide a continuously available electronic mail communication link (e-mail system) to facilitate communication with DHH, DHH's Fiscal Agent, and CCN and any CCN agent, and GNOCHC PCMH. 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. As needed, the EB shall be able to communicate with DHH over a secure Virtual Private Network (VPN). The EB 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.

9.13. Address Standardization

The EB's Systems shall utilize mailing address standards in accordance with the United States Postal Service.

9.14. Electronic Medical Records

At such time that DHH requires, the EB 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).

9.15. HIPAA-Based Formatting Standards

The System shall conform to the following HIPAA-compliant standards for information exchange. Batch transaction types include, but are not limited to, the following:

- ASC X12N 834 Benefit Enrollment and Maintenance;
- ASC X12N 835 Claims Payment Remittance Advice Transaction;
- ASC X12N 837I Institutional Claim/Encounter Transaction;
- ASC X12N 837P Professional Claim/Encounter Transaction;
- ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;
- ASC X12N 276 Claims Status Inquiry;
- ASC X12N 277 Claims Status Response;
- ASC X12N 278/279 Utilization Review Inquiry/Response; and
- ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products.

Transaction types are subject to change and the EB shall comply with applicable federal and HIPAA standards and regulations as they occur.

9.16. Audit Requirements

9.16.1. The EB shall ensure that their Systems facilitate the auditing of detailed information. Adequate audit trails shall be provided throughout the Systems.

9.16.2. The EB shall maintain and adhere to an internal Electronic Data Policy and Procedures (EDP) 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.

9.16.3. State Audit

9.16.3.1. The EB 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 EB shall provide information necessary to assist the state auditor in processing or utilizing the files.

9.16.3.2. If the auditor's findings point to discrepancies or errors, the EB shall provide a written corrective action plan to DHH within ten (10) business days of receipt of the audit report.

9.16.3.3. 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 EB's EDP manual.

9.16.4. Independent Audit

9.16.4.1. The EB 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 EB's Systems application. The independent firm shall:

- Perform limited scope EDP audits on an ongoing and annual basis using DHH's audit program specifications at the conclusion of the first twelve (12) month operation period and each twelve (12) month period thereafter, while the contract is in force with DHH and at the conclusion of the contract; and

- Perform a comprehensive audit on an annual basis to determine the EB's compliance with the obligations specified in the contract.

9.16.4.2. The auditing firm shall deliver to the EB 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.

9.16.4.3. DHH shall use the findings and recommendations of each report as part of its monitoring process.

9.16.4.4. The EB 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 EB's EDP manual.

9.16.5. Systems Refresh Plan

9.16.5.1. The EB shall provide to DHH an annual Systems Refresh Plan. The plan shall outline how Systems within the EB'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.

9.16.5.2. The systems refresh plan shall also indicate how the EB 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.

9.16.6. Configuration Management

9.16.6.1. The EB must develop and implement a Configuration Management process that includes procedures to track hardware and software inventories installed and the combination of hardware and software residing on each component of equipment. This applies to any hardware and software assigned from HHSC as well as any expansion or replacement hardware and software.

9.16.6.2. The EB must design, implement, and maintain a Configuration Management Plan including an overall approach for tracking and managing hardware and software inventories, including version control. Implement approved plan no later fifteen (15) calendar days after receipt of approval by DHH.

9.16.6.3. The EB shall develop an overall approach for tracking and managing hardware and software that resides on each component of equipment.

9.16.7. Security Management

9.16.7.1. The EB will be responsible for providing comprehensive security. To ensure consistency in clients' access to services statewide and mitigate risks to the State and taxpayers, the vendor must provide a Security Management Plan for both the implementation and transition phase.

9.16.7.2. The EB must develop and implement a Security Management solution that includes methods for resolving the following major security concerns for system development and transition:

- Environmental security;
- Physical site security;
- Computer hardware security;
- Computer software security;
- Data access and storage;
- Client/user security;
- Telecommunications security; and
- Network security.

9.16.7.3. The EB shall develop and submit a Security Management Plan within thirty-five (35) business days after contract execution, which includes an overall approach for establishing and maintaining security that meets all state and federal requirements, including Federal Tax Information and HIPAA, and protects against unauthorized access.

9.16.7.4. The EB must execute the approved Security Management Plan within sixty (60) calendar days after contract execution, or later date as specified by DHH.

9.16.7.5. The EB shall develop and implement methods that ensure security for all components of the system including:

- Environmental security;
- Physical site security;
- Computer hardware security;
- Computer software security;
- Data access and storage;
- Client/user security;
- Telecommunications security; and
- Network security

9.16.7.6. The EB shall develop and implement a process for documenting, tracking, monitoring and reporting security issues to the State.

9.16.7.7. The EB must use a subcontractor whose core business is providing physical site security unless provision of physical site security is a part of the vendor's core business operation.

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10. CONTRACT MONITORING

10.1. The Bureau of Health Services Financing (BHSF) (Medicaid) establishes the policy and procedural requirements which the EB must follow. DHH will assign a contract monitor as the liaison and point of contact between the Department and the EB. The contract monitor will be primarily responsible for input regarding the components of the contract.

10.2. The EB shall submit all procedures and written material for approval by the Department. The Department will continue to have approval over all manuals, policies and procedures related to the design, development and implementation of the components of this RFP. The contract monitor shall be notified timely and will participate in meetings coordinated with the Fiscal Intermediary, public and private groups, including conferences and seminar presentations.

10.3. The Department will provide functional supervision of the EB's responsibility, including on-going meetings. In addition, the Department will be the liaison between the EB and local state and national committees, providers, professional organizations, other state agencies and other health care entities.

10.4. To perform the functions of the contract adequately, interaction between the MMIS systems and EB is necessary. The Department staff will coordinate the interface and the MMIS files will be the driving files in all cases. The EB will provide computer and networking equipment required to input and access data as specified by the Fiscal Intermediary and approved by the Department.

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11. PROPOSAL SUBMISSION AND EVALUATION CRITERIA

11.1. General Information

11.1.1. This section outlines the provisions which govern determination of compliance of each proposer's response to the RFP. The Department shall determine, at its sole discretion, whether or not the requirements have been reasonably met. Omissions of required information shall be grounds for rejection of the proposal by the Department.

11.1.2. 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.

11.2. 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.

11.3. Rejection and Cancellation

11.3.1. 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.

11.3.2. 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.

11.4. 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 the contract. The Louisiana Board of Ethics is they only entity which can officially rule on ethics issues.

11.5. Award Without Discussion

The Secretary of DHH reserves the right to make an award without presentations by proposers or further discussion of proposals received.

11.6. 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.

11.7. Errors and Omissions

11.7.1. The State reserves the right to make corrections due to minor errors of proposer identified in the proposal by State or the proposer. The State, at its option, has the right to request clarification or additional information from proposer.

11.7.2. Discovery of any inaccuracy in this date will not constitute a basis for contract rejection by any Broker. Discovery of any inaccuracy in this data will not constitute a basis for renegotiation of any payment rate after contract award. It is the EB's responsibility to take into consideration normal volume increases over the contract period.

11.8. Additional Information

Proposers may be required by DHH to provide additional information or clarification concerning proposals.

11.9. Interpretive Conventions

11.9.1. 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.

11.9.2. Whenever the terms "can," "may," or "should" are used in this RFP in conjunction with a specification or performance requirement, the specification or performance requirement is a desirable, but not mandatory, requirement. Accordingly, a Respondent's failure to address or provide any items so referred to will not be the cause for rejection of the proposal, but will likely result in a less favorable evaluation.

11.10. 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.

11.11. Ownership of Proposal

All proposals become the property of the Department and will not be returned to the proposer. The Department 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.

11.12. Procurement Library/Resources Available To Proposer

11.12.1. Department program manuals and pertinent Federal and State regulations, as well as other pertinent materials, are available upon request in the Procurement Library. The library is located at www.MakingMedicaidBetter.com .

11.12.2. 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

11.13. Proposal Submission

11.13.1. 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.

11.13.2. Proposer must submit one (1) original and should submit eight (8) copies of proposals. One electronic copy of the proposal should also be submitted with the original. Proposals, with the exception of the electronic copy, must be submitted in hard copy form, no facsimile or emailed proposals will be accepted.

11.13.3. Proposals must be submitted via U.S. mail, courier or hand delivered to:

If courier mail or hand delivered:

Mary Fuentes
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 Fuentes
Department of Health and Hospitals
Division of Contracts and Procurement Support
P.O. Box 1526
Baton Rouge, LA 70821-1526

11.14. Proprietary and/or Confidential Information

11.14.1. The designation of certain information as trade secrets and/or privileged or confidential proprietary information shall only apply to the technical portion of the proposal. The cost proposal will not be considered confidential under any circumstances. Any proposal copyrighted or marked as confidential or proprietary in its entirety may be rejected without further consideration or recourse.

11.14.2. 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 Technical Proposal. Proposers should refer to the Louisiana Public Records Act for further clarification.

11.14.3. 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."*

11.14.4. Further, to protect such data, each page containing such data shall be specifically identified and marked "CONFIDENTIAL".

11.14.5. 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 agree to indemnify DHH and hold DHH harmless against all actions or court proceedings that may ensue (including attorney's fees), which seek to order DHH to disclose the information. If the owner of the asserted data refuses to indemnify and hold DHH harmless, DHH may disclose the information

11.14.6. If the proposal contains confidential information, a redacted copy of the proposal must be submitted. If a redacted copy is not submitted, proposer will be required to submit this copy within 48 hours of notification from DHH. When submitting the redacted copy, it should be clearly marked on the cover as - "REDACTED COPY" to avoid having this copy reviewed by an evaluation committee member. The redacted copy should also state which sections or information has been removed."

11.14.7. Any proposal marked as confidential or proprietary in its entirety may be rejected without further consideration or recourse.

11.15. Proposal Format

11.15.1. Each proposal should be economically prepared, with emphasis on completeness and clarity of content. A proposal, as well as any reference material presented, must be written in English and must be typed on standard 8 1/2" x 11" paper with recommended margins of one inch. It should be single spaced with text no smaller than 11-point font; pages may be single sided or double sided. All proposal pages should be numbered and identified with the Proposer's name. Material should be sequentially filed in three ring binders no larger than three inches in thickness.

11.15.2. The RFP and EB Proposal Submission and Evaluation Requirements (Appendix G) details the specific requirements for making a Proposal in response to this RFP.

11.15.3. 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 EB Proposal Submission and Evaluation Requirements, Section A and use as the Table of Contents.

11.15.4. The response to the Technical Requirements Sections (Sections B-P) should be in separate binder (s) and clearly labeled with contents. The Proposer should duplicate the EB Proposal Submission and Evaluation Requirements, Section B-P and use as the Table of Contents. The response to each subsection (B, C, D, E, F…) should be clearly tabbed and labeled.

11.15.5. Attachments should only be provided as requested in the EB 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.

11.15.6. 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.

11.16. Proposal Content

11.16.1. 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.

11.16.2. 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.

11.16.3. 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.

11.16.4. The Proposer may not submit the Proposer's own contract terms and conditions or other requirements in a response to this RFP.

11.17. Evaluation Criteria

The following criteria (see Appendix G) will be used to evaluate proposals:

11.17.1. Scoring will be based on a possible total of 2,000 and the proposal with the highest total score will be recommended for award.

11.17.2. Cost Evaluation:

11.17.2.1. The proposer with the lowest total cost for the first thirty-six (36) months of the contract shall receive 400 points. Other proposers shall receive points for cost based upon the following formula:

CPS = (LPC/PC)* 400

CPS = Cost Proposal Score
LPC = Lowest Proposal Cost of all proposers
PC = Individual Proposal Cost

Total Cost = (PMPM x Total Member Months for CY1) + (PMPM x Total Member Months for CY2) + (PMPM x Total Member Months for CY3)

See Appendix K - Projected CCN Member Months for Enrollment Broker Use in Making PMPM Price Projections).

11.17.2.2. The assignment of the 400 points based on the above formula will be calculated by a member of the DHH Contracts Office staff.

11.17.2.3. Additionally, a maximum of 100 points will be awarded for the cost criteria based on evaluation of reasonableness of cost based on economies of scale, adequate budget detail, and justification that all cost is consistent with the purpose, objectives, and deliverables of the RFP.

11.17.2.4. The DHH Undersecretary may provide information to assist with the evaluation of reasonableness of cost.

11.17.3. Evaluation Criteria and Assigned Weights

PART I – MANDATORY

Section	Category	Evaluation Team	Total Possible Points
A	Mandatory Requirements	DHH Contract Review	0

PART II – TECHNICAL- Total Possible Points – 2,000

Section	Category	Total Possible Points
B	Qualifications and Experience	125
C	Planned Approach to Project	135
D	Member Enrollment and Disenrollment	400
E	Member Material	50
F	Call Monitoring and Case Accuracy	100
G	Call Center – Customer Service	165
H	Record Keeping Requirements	50
I	Reporting Requirements	100
J	Transition Plan	50
K	Fraud and Abuse	25
L	Technical Requirements/Information Systems	250
M	Emergency Management Plan	25
N	Proposer's Financial Statement	25
O	Proposal Cost Analysis	500

11.17.3.1. All proposals will be reviewed and scored for each Section by a Proposal Review Team (PRT), comprised of three or more DHH employees.

11.17.3.2. 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.

11.17.3.3. Evaluations of the financial statements will be conducted by a member of the DHH Fiscal Division and other appropriate staff.

11.17.3.4. 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.

11.17.3.5. Proposals containing assumptions, lack of sufficient detail, poor organization, lack of proofreading and unnecessary use of self-promotional claims will be evaluated accordingly.

11.17.3.6. DHH reserves the right, at its sole discretion, to request Proposer clarification of a Proposal provision or section or to conduct clarification discussions with any or all Proposers. Any such clarification or discussion shall be limited to specific sections of the proposal identified by DHH. The subject Proposer shall put any resulting clarification in writing as may be required by DHH.

11.18. Announcement of Award

The Department will recommend award of the contract to the proposer with the highest graded proposal and deemed to be in the best interest of the Department. All proposers will be notified of the contract award. The Department will notify the successful proposer and proceed to negotiate contract terms. DHH reserves the right not to award a contract.

11.19. Notice of Contract Award

The notice of intended contract award shall be sent in writing to the winning proposers. No proposer shall infer or be construed to have any rights or interest to a contract with DHH until both the proposer and DHH have executed a valid contract and final approval is received from all necessary entities.

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12. CONTRACTUAL INFORMATION

12.1. The contract between DHH and the contractor shall include the standard DHH contract form (CF-1/attached) including a negotiated scope of work, the RFP and its amendments and addenda, and the contractor's proposal. The attached CF-1 contains basic information and general terms and conditions of the contract to be awarded.

12.2. Mutual Obligations and Responsibilities

The state requires that the mutual obligations and responsibilities of DHH and the successful proposer be recorded in a written contract. While final wording will be resolved at contract time, the intent of the provisions will not be altered and will include all provisions as specified in the attached CF-1.

12.3. Performance Bond

For all contractors (for profit or not for profit) awarded contracts through the RFP; the Department shall require the successful proposer, within 10 days of signing the contract, to procure, submit, and maintain a Performance Bond in the amount of 10% of the annual contract amount.

OR

12.4. Retainage

As an alternative to a performance bond requirement above, the Department, at the request of the successful proposer and acceptance by the Department, may secure a retainage of 10% from all billings under the contract as surety for performance. On successful completion of contract deliverables, the retainage amount may be released on an annual basis.

12.5. Terms and Conditions

In addition, to terms of the CF-1 and supplements, the following will be incorporated into the contract awarded through this RFP:

12.5.1. Personnel Assignments

The contractor's key personnel assigned to this contract may not be replaced without the written consent of the Department. Such consent shall not be unreasonably withheld or delayed provided an equally qualified replacement is offered. Key personnel for these purposes will be determined during contract negotiations.

12.5.2. Force Majeure

The contractor and the Department are excused from performance under contract for any period they may be prevented from performance by an Act of God, strike, war, civil disturbance, epidemic or court order.

12.5.3. Order of Precedence

The contract shall, to the extent possible, be construed to give effect to all provisions contained therein; however, where provisions conflict, the intent of the parties shall be determined by giving a first priority to provisions of the contract excluding the RFP and the proposal; second priority to the provisions of the RFP; and third priority to the provisions of the proposal.

12.5.4. Entire Agreement

This contract, together with the RFP and addenda issued thereto by the Department, the proposal submitted by the contractor in response to the Department's RFP, and any exhibits specifically incorporated herein by reference constitute the entire agreement between the parties with respect o the subject matter.

12.5.5. Board Resolution/Signature Authority

The contractor, 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.

12.5.6. Warranty to Comply with State and Federal Regulations

The contractor 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.

12.5.7. Warranty of Removal of Conflict of Interest

The contractor 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 contractor shall periodically inquire of its officers and employees concerning such conflicts, and shall inform the Department promptly of any potential conflict. The contractor shall warrant that it shall remove any conflict of interest prior to signing the contract.

12.5.8. Corporation

If the contractor is a corporation, the following requirement must be met prior to execution of the contract:

- If a for-profit corporation whose stock is not publicly traded-the contractor must file a Disclosure of Ownership form with the Louisiana Secretary of State.

- If the contractor is a corporation not incorporated under the laws of the State of Louisiana, the contractor must obtain a Certificate of Authority pursuant to R.S. 12:301-302 from the Louisiana Secretary of State.

- The contractor must provide written assurance to the agency from contractor's legal counsel that the contractor is not prohibited by its articles of incorporation, by-laws or the laws under which it is incorporated from performing the services required under the contract.

12.5.9. Conflict of Interest

The contractor may not contract with Louisiana Medicaid unless such safeguards at least equal to federal safeguards (41 USC 423, section 27) are in place per State Medicaid Director letter dated December 30, 1997 and Section 1932 (d)(3) of the Social Security Act addressing Section 1932 State Plan Amendment and the default enrollment process under the State Plan Amendment option.

12.5.10. Confidentiality of Information

12.5.10.1. The contractor shall assure that all material and information, in particular information relating to members or potential members, which is provided to or obtained by or through the contractor's performance under this contract, whether verbal, written, electronic file, or otherwise, shall be treated as confidential information to the extent confidential treatment is provided under state and federal laws and regulations. The contractor 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.

12.5.10.2. All information as to personal facts and circumstances concerning members or potential members obtained by the contractor 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.

12.5.11. Contract Language Interpretation

In the event of a disagreement regarding, arising out of, or related to, contract language interpretation, DHH's interpretation of the contract language in dispute shall control and govern.

12.5.12. Cooperation With Other Contractors

In the event that DHH has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder including but not limited to fiscal intermediary and education and outreach services, the contractor agrees to cooperate fully with such other contractors. The contractor shall not commit any act that will interfere with the performance of work by any other contractor.

The contractor's failure to cooperate and comply with this provision, shall be sufficient grounds for DHH to halt all payments due or owing to the contractor until it becomes compliant with this or any other contract provision. DHH's determination on the matter shall be conclusive and not subject to Appeal.

12.5.13. Effect of Termination on CCN's HIPAA Privacy Requirements

12.5.13.1. Except as provided in this RFP, upon termination of this contract for any reason, the contractor shall return or destroy all Protected Health Information received from DHH, or created or received by the contractor on behalf of DHH. This provision shall also apply to Protected Health Information that is in the possession of sub-contractors or of agents the contractor. The contractor shall not retain any copies of the Protected Health Information.

12.5.13.2. In the event that the contractor determines that returning or destroying the Protected Health Information is not feasible, the contractor 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 contractor 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 contractor maintains such Protected Health Information.

12.5.14. Employment of Personnel

12.5.14.1. In all hiring or employment made possible by or resulting from this contract, the contractor agrees that:

- There shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, or national origin; and

- 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.

12.5.14.2. 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 contractor 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 ontractor concerning employment shall be answered without regard to handicap, age, race, color, religion, sex, or national origin. All responses to inquiries made to the contractor concerning employment made possible as a result of this contract shall conform to federal, state, and local regulations.

12.5.15. Entire Contract

The contractor 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 contractor 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 contractor shall comply with all applicable DHH manuals, rules and regulations, policies and procedures in effect throughout the duration of the contract period. Where the provisions of the contract differ from the requirements set forth in the guides, handbooks and/or manuals, the contract provisions shall control.

DHH, at its discretion, will issue correspondence to inform the contractor of changes in policies and procedures which may affect the contract. Unless otherwise specified the contractor will be given sixty (60) calendar days to implement such changes.

12.5.16. HIPAA

12.5.16.1. HIPAA Business Associate

Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as agreed upon in HIPAA Business Associate Agreement. (See Appendix C)

12.5.16.2. Compliance

The contractor 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 contractorshall 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.

12.5.17. Hold Harmless

12.5.17.1. The contractor shall indemnify, defend, protect, and hold harmless DHH and any of its officers, agents, and employees from:

a) Any claims for damages or losses arising from services rendered by any sub-contractor, person, or firm performing or supplying services, materials, or supplies for the contractor in connection with the performance of this contract;

b) 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 contractor, its agents, officers, employees, or subcontractors in the performance of this contract;

c) Any claims for damages or losses resulting to any person or firm injured or damaged by the contractor, its agents, officers, employees, or sub-contractors by contractor'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;

d) Any failure of the contractor, its agents, officers, employees, or subcontractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;

e) 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;

f) Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHH or its agents, officers or employees, through the intentional conduct, negligence or omission of the contractor, its agents, officers, employees or subcontractors.

12.5.17.2. In the event that, due to circumstances not reasonably within the control of contractor or DHH, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither the contractor, DHH, or subcontractor(s), will have any liability or obligation on account of reasonable delay in the provision or the arrangement of services; provided, however, that so long as this contract remains in full force and effect, the contractorshall be liable for the services required to be provided or arranged for in accordance with this contract.

12.5.17.3. DHH will provide prompt notice of any claim against it that is subject to indemnification by contractor under this contract. The contractor 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 contractor, which shall not be unreasonably withheld.

12.5.18. Incorporation of Schedules/Appendices

All schedules/appendices referred to in this RFP are expressly made a part hereof, and are incorporated as if fully set forth herein.

12.5.19. Interpretation Dispute Resolution Procedure

12.5.19.1. The contractor may request in writing an interpretation of the issues relating to the contract from the Medicaid CCN

Program Director. In the event the contractor disputes the interpretation by the Medicaid CCN Program Director, the contractor shall submit a written reconsideration request to the Medicaid Director.

12.5.19.2. The contractor shall submit, within-twenty-one (21) days of said interpretation disputing the interpretation. The ability to dispute an interpretation does not apply to language in the contract that is based on federal or state statute, regulation or case law.

12.5.19.3. The Medicaid Director shall reduce his/her decision to writing and provide a copy to the contractor. The written decision of the Medicaid Director shall be the final decision of DHH. The Medicaid Director will render this final decision based upon the written submission of the contractorand the Medicaid CCN Program Director, unless, at the sole discretion of the Medicaid Director, the Medicaid Director allows an oral presentation by the contractor 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.

12.5.19.4. Pending final determination of any dispute over a DHH decision, the contractor shall proceed diligently with the performance of the contract and in accordance with the direction of DHH.

12.5.20. Misuse of Symbols, Emblems, or Names in Reference to Medicaid

No person or contractor 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.

12.5.21. 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:

12.5.21.1. The body of the contract excluding the RFP and the proposal.

12.5.21.2. This RFP and any appendices.

12.5.21.3. The proposal submitted by the CCN in response to this RFP.

12.5.22. 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".

12.5.23. 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 contractor 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 contractor will be discharged from further obligations created under the terms of the contract.

12.5.24. Software Reporting Requirement

All reports submitted to DHH by the contractor 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.

12.5.25. 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 contractor or any other party for any costs, expenses, or damages occasioned by said termination, i.e., the termination by DHH shall be without penalty. The contractor shall be responsible to adhere to the requirements specified in Transition Plan (See Appendix I).

12.5.26. Termination for Unavailability of Funds

12.5.26.1. In the event that federal and/or state funds to finance this contract become unavailable after the effective date of this contract, or prior to the anticipated contract expiration date, DHH may terminate the Contract without penalty. This notification will be made in writing. Availability of funds shall be determined solely by DHH.

12.5.26.2. The contractor shall comply with all requirements specified in Appendix I – Transition Plan and the termination requirements in this RFP.

12.5.27. Titles

All titles used herein are for the purpose of clarification and shall not be construed to infer a contractual construction of language.

12.5.28. 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 contractor resulting from this contract.

12.5.29. Time Is Of The Essence

Time is of the essence in this contract. Any reference to “days” shall be deemed calendar days unless otherwise specifically stated.

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APPENDICES

APPENDIX A

PROPOSAL CERTIFICATION STATEMENT

CERTIFICATION STATEMENT

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Request for Proposals (RFP), including attachments.

OFFICIAL CONTACT: The State requests that the Proposer designate one person to receive all documents and the method in which the documents are best delivered. Identify the Contact name and fill in the information below: (Print Clearly)

Date	
Official Contact Name	
Email Address	
Fax Number with Area Code	
Telephone Number	
Street Address	
City, State, and Zip	

Proposer certifies that the above information is true and grants permission to the Department to contact the above named person or otherwise verify the information I have provided.

By its submission of this proposal and authorized signature below, proposer certifies that:

1. The information contained in its response to this RFP is accurate;
2. Proposer accepts the procedures, evaluation criteria, contract terms and conditions, and all other administrative requirements set forth in this RFP.
3. Proposer accepts the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP.
4. Proposer's quote is valid for at least 120 days from the date of proposal's signature below;
5. Proposer understands that if selected as the successful Proposer, he/she will have seven (7) business days from the date of delivery of initial contract in which to complete contract negotiations, if any, and execute the final contract document. The Department has the option to waive this deadline if actions or inactions by the Department cause the delay.
6. Proposer certifies, by signing and submitting a proposal for $25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in OMB Circular A-133. (A list of parties who have been suspended or debarred can be viewed via the internet at www.epls.gov

Authorized Signature: _____

Typed or Printed Name: _____

Title: _____

Company Name: _____

APPENDIX B

DHH STANDARD CONTRACT FORM

DHH - CF - 1
Revised: 2010-08

CONTRACT BETWEEN STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

CFMS:

DHH:

Agency #

AND

FOR

☐ Personal Services ☐ Professional Services ☐ Consulting Services ☐ Social Services

1) **Contractor (Legal Name if Corporation)**	5) **Federal Employer Tax ID# or Social Security # (Must be 11 Digits)**
2) **Street Address**	6) **Parish(es) Served**
City / **State** LA / **Zip Code**	7) **License or Certification #**
3) **Telephone Number**	8) Contractor Status Subrecipient: ☐ Yes ☐ No Corporation: ☐ Yes ☐ No For Profit: ☐ Yes ☐ No Publicly Traded: ☐ Yes ☐ No
4) **Mailing Address (if different)**	
City / **State** / **Zip Code**	8a) **CFDA#**(Federal Grant #)

9) **Brief Description Of Services To Be Provided:**

10) **Effective Date** 08-01-2011	11) **Termination Date** 07-31-2014

12) This contract may be terminated by DHH upon giving sixty (60) days advance written notice to the other party with or without cause but in no case shall continue beyond the specified termination date.

13) **Maximum Contract Amount**

14) **Terms of Payment**
If progress and/or completion of services are provided to the satisfaction of the initiating Office/Facility, payments are to be made as follows:

Contractor obligated to submit final invoices to Agency within fifteen (15) days after termination of contract.

PAYMENT WILL BE MADE ONLY UPON APPROVAL OF:	**First Name** / **Last Name**
	Title / **Phone Number**

15) **Special or Additional Provisions which are incorporated herein, if any (IF NECESSARY, ATTACH SEPARATE SHEET AND REFERENCE):**

During the performance of this contract, the Contractor hereby agrees to the following terms and conditions:

1. Contractor hereby agrees to adhere as applicable to the mandates dictated by Titles VI and VII of the Civil Rights Act of 1964, as amended; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; Americans with Disabilities Act of 1990 as amended; the Rehabilitation Act of 1973 as amended; Sec. 202 of Executive Order 11246 as amended, and all applicable requirements imposed by or pursuant to the regulations of the U. S. Department of Health and Human Services. Contractor agrees not to discriminate in the rendering of services to and/or employment of individuals because of race, color, religion, sex, age, national origin, handicap, political beliefs, disabled veteran, veteran status, or any other non-merit factor.

2. Contractor shall abide by the laws and regulations concerning confidentially which safeguard information and the patient/client confidentiality. Information obtained shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (The Contractor shall establish, subject to review and approval of the Department, confidentiality rules and facility access procedures.)

3. The State Legislative Auditor, Office of the Governor, Division of Administration, and Department Auditors or those designated by the Department shall have the option of auditing all accounts pertaining to this contract during the contract and for a three year period following final payment. Contractor grants to the State of Louisiana, through the Office of the Legislative Auditor, Department of Health and Hospitals, and Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours.

   Contractor shall comply with federal and state laws and/or DHH Policy requiring an audit of the Contractor's operation as a whole or of specific program activities. Audit reports shall be sent within thirty (30) days after the completion of the audit, but no later than six (6) months after the end of the audit period. If an audit is performed within the contract period, for any period, four (4) copies of the audit report shall be sent to the Department of Health and Hospitals, Attention: **Division of Fiscal Management, P.O. Box 91117, Baton Rouge, LA 70821-3797** and one (1) copy of the audit shall be sent to the **originating DHH Office**.

4. Contractor agrees to retain all books, records and other documents relevant to the contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 74:53 (b) whichever is longer. Contractor shall make available to the Department such records within thirty (30) days of the Department's written request and shall deliver such records to the Department's central office in Baton Rouge, Louisiana, all without expense to the Department. Contractor shall allow the Department to inspect, audit or copy records at the contractor's site, without expense to the Department.

5. Contractor shall not assign any interest in this contract and shall not transfer any interest in the same (whether by assignment or novation), without written consent of the Department thereto, provided, however, that claims for money due or to become due to Contractor from the Department under this contract may be assigned to a bank, trust company or other financial institution without advanced approval. Notice of any such assignment or transfer shall be promptly furnished to the Department and the Division of Administration, Office of Contractual Review.

6. Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this contract shall be Contractor's. The contractor assumes responsibility for its personnel providing services hereunder and shall make all deductions for withholding taxes, and contributions for unemployment compensation funds.

7. Contractor shall obtain and maintain during the contract term all necessary insurance including automobile insurance, workers' compensation insurance, and general liability insurance. The required insurances shall protect the Contractor, the Department of Health and Hospitals, and the State of Louisiana from all claims related to Contractor's performance of this contract. Certificates of Insurance shall be filed with the Department for approval. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days advance written notice to the Department. Commercial General Liability Insurance shall provide protection during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as claims for property damages, with combined single limits prescribed by the Department.

8. In cases where travel and related expenses are required to be identified separate from the fee for services, such costs shall be in accordance with State Travel Regulations. The contract contains a maximum compensation which shall be inclusive of all charges including fees and travel expenses.

9. No funds provided herein shall be used to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition or any election ballot or a proposition or matter having the effect of law being considered by the legislature or any local governing authority. Contracts with individuals shall be exempt from this provision.

10. Should contractor become an employee of the classified or unclassified service of the State of Louisiana during the effective period of the contract, Contractor must notify his/her appointing authority of any existing contract with State of Louisiana and notify the contracting office of any additional state employment. This is applicable only to contracts with individuals.

11. All non-third party software and source code, records, reports, documents and other material delivered or transmitted to Contractor by State shall remain the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract. All non-third party software and source code, records, reports, documents, or other material related to this contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract.

12. Contractor shall not enter into any subcontract for work or services contemplated under this contract without obtaining prior written approval of the Department. Any subcontracts approved by the Department shall be subject to conditions and provisions as the Department may deem necessary; provided, however, that notwithstanding the foregoing, unless otherwise provided in this contract, such prior written approval shall not be required for the purchase by the contractor of supplies and services which are incidental but necessary for the performance of the work required under this contract. No subcontract shall relieve the Contractor of the responsibility for the performance of contractual obligations described herein.

13. No person and no entity providing services pursuant to this contract on behalf of contractor or any subcontractor is prohibited from providing such services by the provisions of R.S. 1113 as amended in the 2008 Regular Session of the Louisiana Legislature.

14. No claim for services furnished or requested for reimbursement by Contractor, not provided for in this contract, shall be allowed by the Department. In the event the Department determines that certain costs which have been reimbursed to Contractor pursuant to this or previous contracts are not allowable, the Department shall have the right to set off and withhold said amounts from any amount due the Contractor under this contract for costs that are allowable.

15. This contract is subject to and conditioned upon the availability and appropriation of Federal and/or State funds; and no liability or obligation for payment will develop between the parties until the contract has been approved by required authorities of the Department; and, if contract exceeds $20,000, the Director of the Office of Contractual Review, Division of Administration in accordance with La. R.S. 39:1502..

16. The continuation of this contract is contingent upon the appropriation of funds from the legislature to fulfill the requirements of the contract. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

17. Any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when reduced to writing, as an amendment duly signed, and approved by required authorities of the Department; and, if contract exceeds $20,000, approved by the Director of the Office of Contractual Review, Division of Administration. Budget revisions approved by both parties in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.

18. Any contract disputes will be interpreted under applicable Louisiana laws and regulations in Louisiana administrative tribunals or district courts as appropriate.

19. Contractor will warrant all materials, products and/or services produced hereunder will not infringe upon or violate any patent, copyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against DHH, the Department shall promptly notify Contractor in writing and Contractor shall defend such claim in DHH’s name, but at Contractor’s expense and shall indemnify and hold harmless DHH against any loss, expense or liability arising out of such claim, whether or not such claim is successful. This provision is not applicable to contracts with physicians, psychiatrists, psychologists or other allied health providers solely for medical services.

20. Any equipment purchased under this contract remains the property of the Contractor for the period of this contract and future continuing contracts for the provision of the same services. Contractor must submit vendor invoice with reimbursement request. For the purpose of this contract, equipment is defined as any tangible, durable property having a useful life of at least (1) year and acquisition cost of $1000.00 or more. The contractor has the responsibility to submit to the Contract Monitor an inventory list of DHH equipment items when acquired under the contract and any additions to the listing as they occur. Contractor will submit an updated, complete inventory list on a quarterly basis to the Contract Monitor. Contractor agrees that upon termination of contracted services, the equipment purchased under this contract reverts to the Department. Contractor agrees to deliver any such equipment to the Department within 30 days of termination of services.

21. Contractor agrees to protect, indemnify and hold harmless the State of Louisiana, DHH, from all claims for damages, costs, expenses and attorney fees arising in contract or tort from this contract or from any acts or omissions of Contractor’s agents, employees, officers or clients, including premises liability and including any claim based on any theory of strict liability. This provision does not apply to actions or omissions for which LA R.S. 40:1299.39 provides malpractice coverage to the contractor, nor claims related to treatment and performance of evaluations of persons when such persons cause harm to third parties (R.S. 13:5108.1(E)). Further it does not apply to premises liability when the services are being performed on premises owned and operated by DHH.

22. Any provision of this contract is severable if that provision is in violation of the laws of the State of Louisiana or the United States, or becomes inoperative due to changes in State and Federal law, or applicable State or Federal regulations.

23. Contractor agrees that the current contract supersedes all previous contracts, negotiations, and all other communications between the parties with respect to the subject matter of the current contract.

THIS CONTRACT CONTAINS OR HAS ATTACHED HERETO ALL THE TERMS AND CONDITIONS AGREED UPON BY THE CONTRACTING PARTIES. IN WITNESS THEREOF, THIS CONTRACT IS SIGNED ON THE DATE INDICATED BELOW.

	STATE OF LOUISIANA **DEPARTMENT OF HEALTH AND HOSPITALS**
SIGNATURE **DATE**	**SIGNATURE** **DATE**
NAME	**NAME**
	Secretary, Department of Health and Hospital or Designee
TITLE	**TITLE**
SIGNATURE **DATE**	**SIGNATURE** **DATE**
NAME	**NAME**
TITLE	**TITLE**

APPENDIX C

HIPAA BUSINESS ASSOCIATE AGREEMENT

HIPAA BUSINESS ASSOCIATE AGREEMENT

A. Purpose

The Louisiana Department of Health and Hospitals (Covered Entity) and the Enrollment Broker (Business Associate) agree to the terms of this Agreement for the purpose of protecting the privacy of individually identifiable health information under the Health Insurance Portability and Accountability Act of 1996, Public Law No. 104-191 ("HIPAA"), and regulations promulgated there under by the U.S. Department of Health and Human Services (the "HIPAA Regulations"); and Subtitle D of the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), also known as Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law No. 111-005 ("ARRA") in performing the functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract between the parties.

B. Definitions (Other terms used but not defined shall have the same meaning as those terms in the HIPAA Privacy Rule.)

1. Business Associate means the same as "business associate" in 45 CFR § 160.103.

2. Covered Entity means DHH.

3. Designated Record Set means the same as "designated record set" in 45 CFR § 164.501.

4. Individual means the same as "individual" in 45 CFR § 160.103 and includes a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

5. Privacy Rule means the HIPAA Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 160 and Part 164, Subparts A and E).

6. Protected Health Information (PHI) means the same as the term protected health information in 45 CFR § 160.103, limited to information received by Agency from Covered Entity.

7. Required By Law means the same as "required by law" in 45 CFR § 164.103, and other law applicable to the PHI disclosed pursuant to the Contract.

8. Secretary means the Secretary of the Department of Health and Hospitals or designee.

9. Security Standards shall mean the Security Standards at 45 C.F.R. Part 160 and Part 164, as may be amended.

10. Electronic PHI shall have the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103.

11. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system or its current meaning under 45 C.F.R. § 164.304.

C. Business Associate Provisions

Business Associate agrees to:

1. Not use or disclose PHI other than as permitted or required by the Contract or as required by law.

2. Use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for in the Contract.

3. Mitigate to the extent practicable, any harmful effect known to Business Associate if it uses/discloses PHI in violation of the Contract.

4. Immediately report to Covered Entity any breaches in privacy or security that compromise PHI. Security and/or privacy breaches should be reported to:

   Louisiana Department of Health and Hospitals
   Bureau of Legal Services
   Post Office Box 3836
   Baton Rouge, Louisiana 70821
   Phone: (225) 342-1112
   Fax: (225) 342-2232

   The Report should include a detailed description of the breach and any measures that have been taken by the Business Associate to mitigate the breach.

   DHH may impose liquidated damages of $300 per day from the date that the Business Associate knew or should have known of any breach in privacy or security that compromises PHI to the date that DHH becomes aware of the breach.

   DHH may impose liquidated damages of up to $25,000 for any breach in privacy or security that compromises PHI.

5. Ensure that any agent/contractor to whom it provides PHI agrees to the same restrictions/conditions that apply to the Business Associate in this Agreement.

6. If the Business Associate has PHI in a designated record set: (1) provide access at Covered Entity's request to PHI to Covered Entity or, as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR § 164.524; (2) make any amendment(s) to PHI in a designated record set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526.

7. Make its internal practices, books, records, and policies/procedures relating to

the use/disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity, to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

8. Document Business Associate disclosures of PHI, other than disclosures back to Covered Entity, and related information as would be required for Covered Entity to respond to a request for an accounting of PHI disclosures in accordance with 45 CFR § 164.528.

9. Provide to Covered Entity or an individual, as designated by Covered Entity, information collected in accordance with Section C.8 of this Agreement, to permit Covered Entity to respond to a request for an accounting of PHI disclosures in accordance with 45 CFR § 164.528.

10. Encrypt all PHI stored on portable devices. Portable devices include all transportable devices that perform computing or data storage, manipulation or transmission including, but not limited to, diskettes, CDs, DVDs, USB flash drives, laptops, PDAs, Blackberrys, cell phones, portable audio/video devices (such as iPODs, and MP3 and MP4 players), and personal organizers.

11. Otherwise, not re-disclose Covered Entity PHI except as permitted by applicable law.

12. Be liable to Covered Entity for any damages, penalties and/or fines assessed against Covered Entity should Covered Entity be found in violation of the HIPAA Privacy Rule due to Business Associate's material breach of this section. Covered Entity is authorized to recoup any and all such damages, penalties and/or fines assessed against Covered Entity by means of withholding and/or offsetting such damages, penalties, and/or fines against any and all sums of money for which Covered Entity may be obligated to the Business Associate under any previous contract and/or this or future contracts. In the event there is no previous contractual relationship between the Business Associate and Covered Entity, the amount to cover such damages, penalties and/or fines shall be due from Business Associate immediately upon notice.

D. Permitted Uses and Disclosures by Business Associate

1. Except as limited in the Contract, Business Associate may use PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use would not violate the Privacy Rule if done by Covered Entity or Covered Entity's privacy practices. Unless otherwise permitted in this Agreement, in the Contract or required by law, Business Associate may not disclose/re-disclose PHI except to Covered Entity.

2. Except as limited in this Agreement, Business Associate may use/disclose PHI for internal management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, as needed for Business Associate to provide its services under the Contract.

3. Except as limited in this Agreement, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).

4. Business Associate may use PHI to report violations to appropriate Federal or State authorities as permitted by § 164.502(j)(1).

E. Covered Entity Provisions

Covered Entity agrees to:

1. Notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

2. Notify Business Associate of any changes in, or revocation of, permission by individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

3. Notify Business Associate of any restriction to the use/disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use/disclosure of PHI.

4. Not request Business Associate to use/disclose PHI in any manner not permitted under the Privacy Rule if done by Covered Entity.

F. Term and Termination

1. The terms of this Agreement shall be effective immediately upon signing of both the Contract and this Agreement, and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is returned to Covered Entity, or, if it is infeasible to return PHI, protections are extended to such PHI in accordance with the termination provisions in this Section.

   a. Upon its knowledge of a material breach by Business Associate, Covered Entity shall either: Allow Business Associate to cure the breach or end the violation and terminate the Contract if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; or
   b. Immediately terminate the Contract if Business Associate has breached a material term of this Agreement and cure is not possible; or
   c. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

2. Effect of Termination

   a. Except as provided in paragraph (b) below, upon termination of the Contract, Business Associate shall return all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision also applies to PHI in the possession of Business Associate's

contractors or agents. Business Associate shall retain no copies of the PHI.

b. If Business Associate determines that returning the PHI is infeasible, Business Associate shall notify Covered Entity of the conditions that make return infeasible. Upon mutual agreement of the parties that return of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return infeasible, for so long as Business Associate maintains such PHI.

G. Security Compliance

Business Associate agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Covered Entity, and will require that its agents and contractors to whom it provides such information do the same. Further, Business Associate agrees to comply with Covered Entity's security policies and procedures. Business Associate also agrees to provide Covered Entity with access to and information concerning Business Associate's security and confidentiality policies, processes, and practices that affect electronic PHI provided to or created by Business Associate pursuant to the Agreement upon reasonable request of the Covered Entity. Covered Entity shall determine if Business Associate's security and confidentiality practices, policies, and processes comply with HIPAA and all regulations promulgated under HIPAA. Additionally, Business Associate will immediately report to Covered Entity any Security Incident of which it becomes aware.

H. Miscellaneous

1. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.

2. The Parties agree to amend this Agreement as necessary to comply with HIPAA and other applicable law.

3. The respective rights and obligations of Business Associate under **§ F. 3** shall survive the termination of the Contract.

4. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

Enrollment Broker Representative	DHH Representative
Title:_____	Title:_____
Please print Name:_____	Please print Name:_____
Date:_____	Date:_____

APPENDIX D

COST TEMPLATE AND INSTRUCTIONS

Cost and Pricing Analysis

The information requested herein shall constitute the Cost Proposal. The Cost Proposal should be placed in a separate sealed envelope within the sealed proposal, separated from the technical submittal.

Proposers shall submit the cost and pricing analysis using the Cost and Pricing Templates for Years 1, 2, and 3 in accordance with the instructions provided below. Proposers shall also include pricing for the optional 2 years.

This Appendix contains the following worksheets:

- Cost and Pricing Template
- Schedule A – Staff Gross Salaries and Staff Numbers
- Comments

Using the Cost and Pricing Templates, detail costs in each respective category by year. The cost proposal shall contain the total cost and be used to determine the respective per member per month (PMPM) rates for 1) CCNs and 2) GNOCHC. (GNOCHC for Contract Years 1 and 2 only).

Overhead includes costs that are not **100%** attributable to the service being completed, but are generally associated with the recurring management or support of the service. General and administrative overhead includes salaries, equipment and other costs related to headquarters management external to the service, but in support of the activity being completed. Specify which cost items are included and the rates used. These costs must be properly allocated and should only include cost allocable to the direct performance or support of the contract.

Instructions for Completing the Cost and Pricing Template are provided below.

Column descriptions

(Column A) Total Proposed Cost:
Use Column A to show the total allowable expected cost of rendering the scope of work identified in the RFP by cost category. Examples of non-allowable expenses include, but are not limited to:

- Advertising and public relations costs
- Entertainment costs
- Fines or penalties
- Fundraising costs
- Litigation costs incurred against the State
- Lobbying costs

(Column B) Coordinated Care Networks (CCNs):
Use Column B to show the total allowable expected cost of rendering the scope of work that are allocable to the administration of CCN enrollment broker functions.

(Column C) Greater New Orleans Community Health Connections (GNOCHC):
Use Column C to show the total allowable expected cost of rendering the scope of work that are allocable to the administration GNOCHC enrollment broker functions.

LINE/COST CATEGORY DESCRIPTIONS
Instructions below provide guidance on the type of costs that must be reported for a given cost category and, where applicable, refer to the supporting schedule where those amounts are further detailed.

(Line 1) Direct Labor Cost (Salary and Wages):
Enter the amount of salaries/wages for Staff that will perform the scope of work. The salary/wage reported should only include salary and wage cost for positions that directly support the scope of work. Detail for positions should be contained in Schedule A. Respective costs by year should match respective cost identified in Schedule A.

(Line 2) Direct Labor Cost Employer Related Expenses (ERE)
Enter the amount of employer related expenditures (ERE) associated with the salaries/wages for personnel reported in Line 1. The following examples of expenses are considered allowable employee benefits eligible for reimbursement: Hospital and medical insurance; Retirement; Social Security; Unemployment compensation; Workers' compensation insurance. Detail for positions should be contained in Schedule A. Respective costs by year should match respective cost identified in Schedule A.

(Line 3) Administrative Labor Salary/Wages:
Enter the amount of administrative staff salary/wages costs associated with administrative support of the contract. Only allocate the portion to support the scope of work. Detail for positions should be contained in Schedule A. Respective costs by year should match respective cost identified in Schedule A.

(Line 4) Direct Labor Cost Employer Related Expenses
Enter the amount of employer related expenditures associated with the salaries/wages for personnel reported in Line 3. Detail for positions should be contained in Schedule A. Respective costs by year should match respective cost identified in Schedule A.

(Line 5) Sub-Contracted Staff:
Enter the cost of contracted staff performing task identified in the scope of work. Detail for positions should be contained in Schedule A. Respective costs by year should match respective cost identified in Schedule A.

(Line 6) Indirect Program Supplies and Costs:
Enter the amount for the cost of program supplies such as office supplies, telephone/communication expenses; insurance expenses; etc.

(Line 7) Other Costs:
Identify and enter the cost of other program expenditures.

(Line 8) Travel Expenditures:
Enter the cost of other travel and transportation to perform the scope of work identified in the RFP. Travel and Subsistence. Itemize transportation, lodging and meals per diem costs separately in the Comment Sheet. Travel and subsistence costs must conform to the requirements of the Louisiana State Travel Regulations PPM 49.

(Line 9) Occupancy Expenditures:
Identify occupancy expenditures and provide any explanations in the Comment Sheet.

(Line 10) Total:
Enter the total of lines 1 through 9 for CCN and GNOCHC. Also identify the total cost for CCN and GNOCHC costs. The total costs for CNC and GNOCHS will be used as the numerator to determine the Per Member Per Month expense for each activity.

Per Member Per Month (PMPM)
(Line 11) Projected Linkages:
This is the number of expected linkages that has been pre-populated DHH and shall used as the calculation figure to determine the PMPM rate.

(Line 12) Year _ PMPM:
This is the calculated PMPM represented for cost for a specific contract year..

(Line 13) Cost Per Program:
This is the proposed PMPM in line12 multiplied by the number of linkages in line 11 for the CCN and GNOCHC respectively for a specific contract year.

(Line 14) CY_ - Total PMPM Cost:
This is the sum of the cost per program in line 13 for the CCN and GNOCHC program for a specific contract year.

Schedule A – Staff Gross Salaries and Staff Numbers

Proposers shall use Schedule A in the Cost Template to calculate the amount for Salary and Wages and ERE to input into the Cost and Pricing Template. Proposer must provide information by contract year.

(Column A) Position:
Enter the job titles in the space provided need to complete the scope of work.

(Column B) Full Time:
Enter the number of full time personnel by position type. FTEs are expected to dedicate 100 percent of time to the scope of work. If less than 100% of time is attributable to the scope of work, then identify as a fractional position. Example, six employees of which 3 are FTEs and 3 work half time; 4.5 FTEs should be reported.

(Column C) Hourly Rate:
Hourly Rate for each staff

(Column D) ERE:
Employer Related Expenses per employee.

(Column E) Provide Total Labor Costs:
Enter the total provider gross salaries and wages paid to full-time. Ensure that the total amount entered corresponds with Schedule A.

(Column F) Provide Total ERE:
Enter the total ERE paid to all eligible staff. Ensure that the total amount entered here corresponds with amount indentified in the Cost and Pricing Template for the respective labor categories.

Comments:
Item 1 - Provide a detailed description of the allocation method used to distribute total provider costs including overhead expenditures.
Item 2 and 3- Provide any additional comments or supporting documentation to facilitate review and support the cost identified.

Appendix # D
Cost and Pricing Template

Proposer Name:				
Year 1 Total Proposed Cost				
		A	**B**	**C**
		Total Proposed Cost	**CCN Cost**	**GNOCHC Cost**
1	Direct Labor Cost (Salary and Wages)			
2	Direct Labor Overhead (Employer Related Expenses)			
3	Administrative Labor Cost			
4	Administrative Labor ERE			
5	Contracted/Subcontracted/Consulting Staff			
6	Indirect Program Supplies			
7	Other Direct Cost			
	- System Development			
	- Web Application			
	- Call Center Expenditures			
	- Education/Outreach Materials			
8	Travel			
9	Occupancy Expenditures			
10	**Total**	0	0	0
Year 1 Cost				
11	**Projected Linkages**		4,252,233	350,000
12	**Year 1 PMPM**		0	0
13	**Cost Per Program**		0.00	0.00
14	**CY 1 - Total PMPM Cost**	0.00		

Appendix # D
Cost and Pricing Template

Proposer Name:				
Year 2 Total Proposed Cost				
		A	**B**	**C**
		Total Proposed Cost	**CCN Cost**	**GNOCHC Cost**
1	Direct Labor Cost (Salary and Wages)			
2	Direct Labor Overhead (Employer Related Expenses)			
3	Administrative Labor Cost			
4	Administrative Labor ERE			
5	Contracted/Subcontracted/Consulting Staff			
6	Indirect Program Supplies			
7	Other Direct Cost			
	- System Development			
	- Web Application			
	- Call Center Expenditures			
	- Education/Outreach Materials			
8	Travel			
9	Occupancy Expenditures			
10	**Total**	0	0	0
Year 2 Cost				
11	**Projected Linkages**		10,617,515	600,000
12	**Year 2 PMPM**		0	0
13	**Cost Per Program**		0.00	0.00
14	**CY 2 - Total PMPM Cost**	0.00		

Appendix # D
Cost and Pricing Template

Proposer Name:				
Year 3 Total Proposed Cost				
		A	**B**	**C**
		Total Proposed Cost	**CCN Cost**	**GNOCHC Cost**
1	Direct Labor Cost (Salary and Wages)			
2	Direct Labor Overhead (Employer Related Expenses)			
3	Administrative Labor Cost			
4	Administrative Labor ERE			
5	Contracted/Subcontracted/Consulting Staff			
6	Indirect Program Supplies			
7	Other Direct Cost			
	- System Development			
	- Web Application			
	- Call Center Expenditures			
	- Education/Outreach Materials			
8	Travel			
9	Occupancy Expenditures			
10	**Total**	0	0	0
Year 3 Cost				
11	**Projected Linkages**		10,829,865	0.00
12	**Year 3 PMPM**			
13	**Cost Per Program**		0.00	0.00
14	**CY 3 - Total PMPM Cost**	0.00		

Appendix # D
Cost and Pricing Template

Proposer Name:				
Year 4 Total Proposed Cost				
		A	**B**	**C**
		Total Proposed Cost	**CCN Cost**	**GNOCHC Cost**
1	Direct Labor Cost (Salary and Wages)			
2	Direct Labor Overhead (Employer Related Expenses)			
3	Administrative Labor Cost			
4	Administrative Labor ERE			
5	Contracted/Subcontracted/Consulting Staff			
6	Indirect Program Supplies			
7	Other Direct Cost			
	- System Development			
	- Web Application			
	- Call Center Expenditures			
	- Education/Outreach Materials			
8	Travel			
9	Occupancy Expenditures			
10	**Total**	0	0	0
Year 4 Cost				
11	**Projected Linkages**		11,046,462	0.00
12	**Year 4 PMPM**			
13	**Cost Per Program**		0.00	0.00
14	**CY 4 - Total PMPM Cost**	0.00		

Appendix # D
Cost and Pricing Template

Proposer Name:				
Year 5 Total Proposed Cost				
		A	**B**	**C**
		Total Proposed Cost	**CCN Cost**	**GNOCHC Cost**
1	Direct Labor Cost (Salary and Wages)			
2	Direct Labor Overhead (Employer Related Expenses)			
3	Administrative Labor Cost			
4	Administrative Labor ERE			
5	Contracted/Subcontracted/Consulting Staff			
6	Indirect Program Supplies			
7	Other Direct Cost			
	- System Development			
	- Web Application			
	- Call Center Expenditures			
	- Education/Outreach Materials			
8	Travel			
9	Occupancy Expenditures			
10	**Total**	0	0	0
Year 5 Cost				
11	**Projected Linkages**		11,267,391	0.00
12	**Year 5 PMPM**			
13	**Cost Per Program**		0.00	0.00
14	**CY 5 - Total PMPM Cost**	0.00		

Appendix # D
Cost and Pricing Template

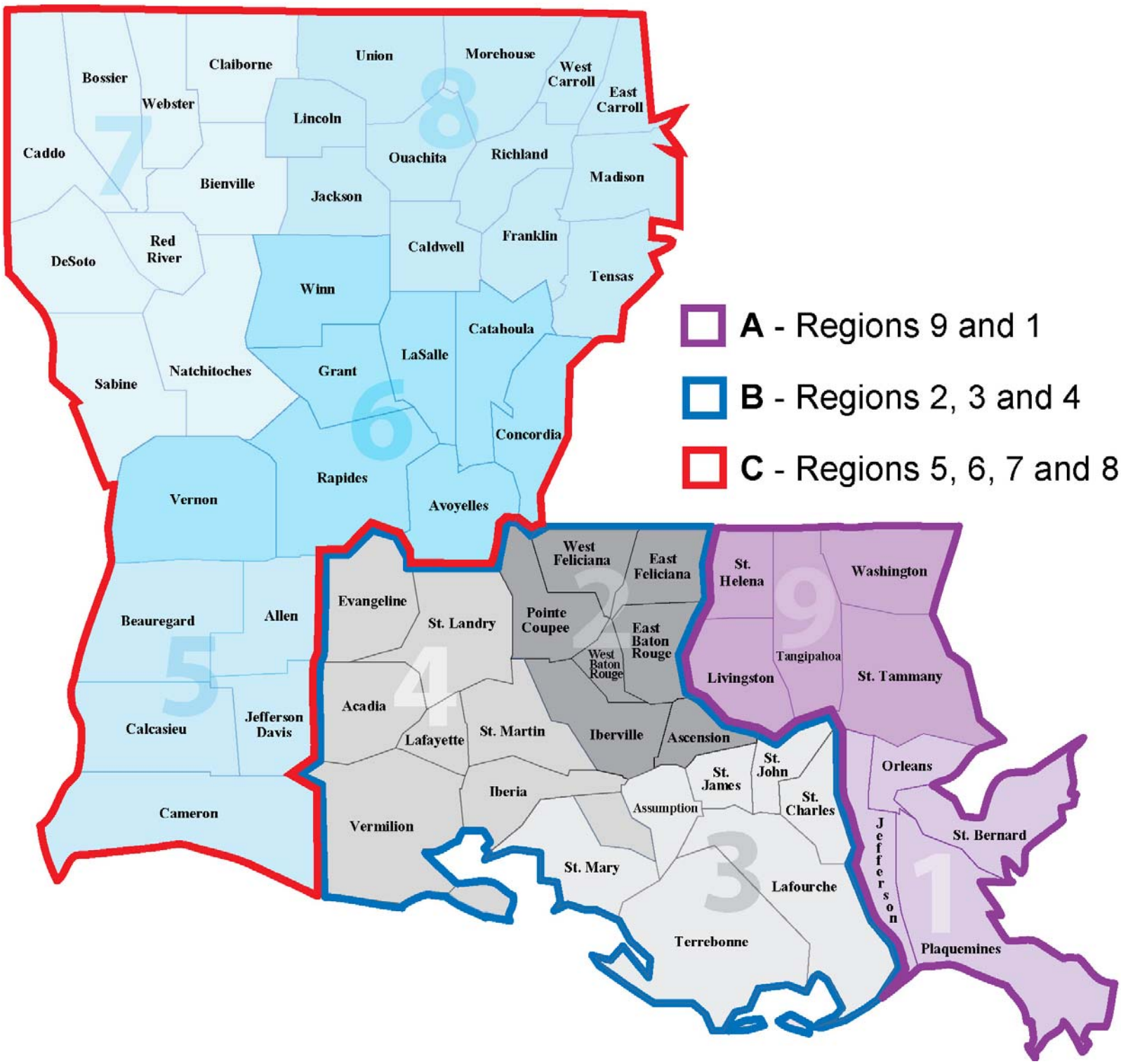
Proposer Name:

Total Proposed Cost For CCN/GNOCHC	
Year 1 - Total Cost	0.00
Year 2 - Total Cost	0.00
Year 3 - Total Cost	0.00
Years 1-3 - Total Cost	0.00
Year 4 - Total Cost	0.00
Year 5 - Total Cost	0.00
Years 1-5 - Total Cost	$ -

APPENDIX E

MAP OF PARISHES WITHIN EACH GSA

Proposed CCN Implementation by Regions



APPENDIX F

FILE SUBMISSION SCHEDULE

Appendix F – FILE SUBMISSION SCHEDULE

Enrollment Broker Responsibilities with CCN Organizations

The Enrollment Broker shall make available to the CCN via a daily and weekly 834 X12 transaction, updates on members newly enrolled, disenrolled or with demographic changes. At the end of each month, the Enrollment Broker shall reconcile enrollment/disenrollment with a full 834 X12 reconciliation file.

Enrollment Broker Responsibilities with DHH MMIS Fiscal Intermediary (FI)

Outlined below is an overall view of the file transactions. Times are subject to change:

Recipient Incremental Update Files – Nightly after Eligibility files are received and processed in the MMIS, except for the last business day of the week. (Note that no update files will be generated on nights of a state holiday). The process would generally be completed by 2:00 am the following morning.

This process will be a two-way exchange between the EB and the FI. The FI will send an update file to the EB containing new Medicaid program enrollments, terminations and changes in enrollment. The EB will send an update file to the FI that contains new CCN linkages, linkage terminations and changes in linkage.

Provider Incremental Update Files – Nightly after Provider file updates have been processed in the MMIS, except for the last business day of the week. (Note that no update files will be generated on nights of a state holiday). The process would generally be completed by 2:00 am the following morning. The FI will send this file to the EB in a one-way exchange.

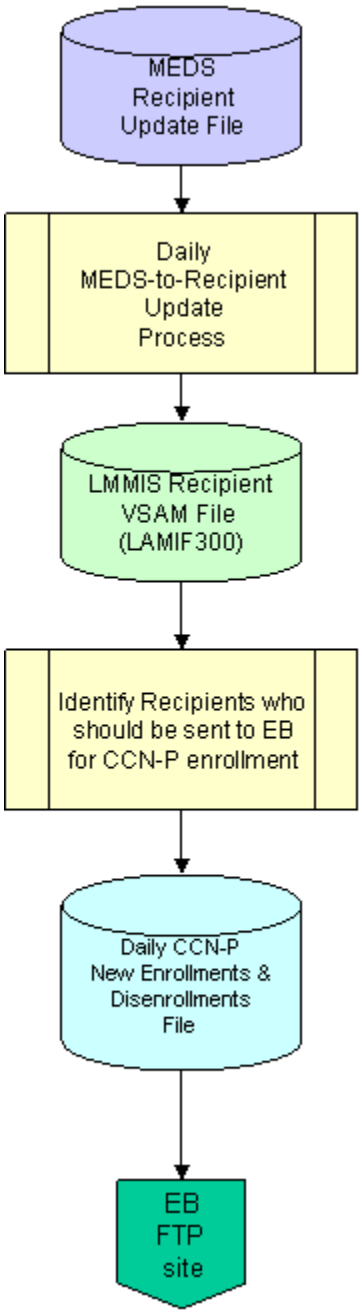
Recipient Full File – Every Sunday evening, generally available at 5:00pm
The FI will send this file to the EB in a one-way exchange.

Provider Full File – Every Sunday evening, generally available at 5:00pm.
The FI will send this file to the EB in a one-way exchange.

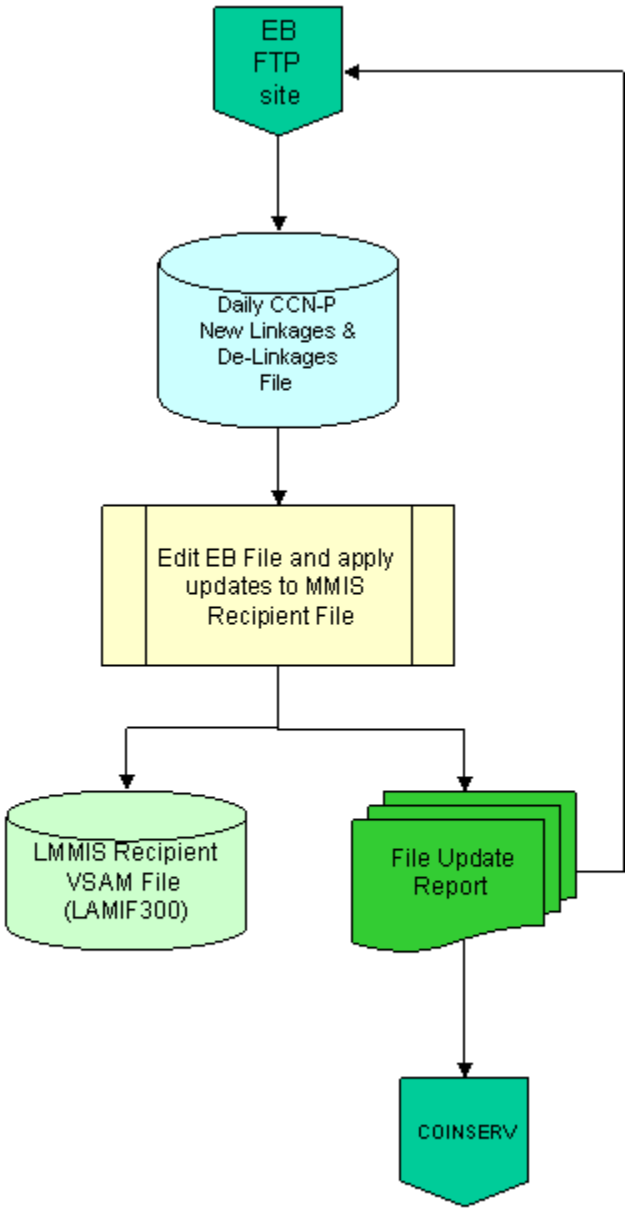
Claims File – Every Tuesday evening, generally available at 5:00pm.
The FI will send this file to the EB in a one-way exchange. The Claims File will consist of all FFS claims processed during the previous week.

The process for these exchanges is depicted in the diagram below. In the diagram, these abbreviations are defined:
COINSERV is the FI's electronic report repository.
FTP is File Transfer Protocol
MEDS is the DHH Medicaid Eligibility Determination System.
MMIS is Louisiana's Medicaid Management Information System.
VSAM is a mainframe database.

FI-to-EB



EB-to-FI



APPENDIX G

PROPOSAL SUBMISSION AND EVALUATION REQUIREMENTS

Appendix G

LOUISIANA COORDINATED CARE NETWORK PROGRAM ENROLLMENT BROKER PROPOSAL SUBMISSION AND EVALUATION REQUIREMENTS RFP # 305PUR-DHHRFP	
A. Mandatory Requirements	0
B. Qualifications and Experience	125
C. Planned Approach to Project	135
D. Member Enrollment and Disenrollment	400
E. Member Material	50
F. Call Monitoring and Case Accuracy	165
G. Call Center – Customer Service	100
H. Record Keeping Requirements	50
I Reporting Requirements	100
J. Transition Plan	50
K. Fraud and Abuse	25
L. Technical Requirements/Information Systems	250
M. Emergency Management Plan	25
N. Proposer's Financial Statement	25
O. Proposal Cost Analysis	500
TOTAL	2,000

LOUISIANA COORDINATED CARE NETWORK PROGRAM
ENROLLMENT BROKER PROPOSAL SUBMISSION AND EVALUATION REQUIREMENTS
RFP # 305PUR-DHHRFP

PROPOSER NAME	

THE PROPOSER MUST COMPLETE THIS FORM AND SUBMIT WITH THEIR PROPOSAL.

PART ONE: MANDATORY REQUIREMENTS

The Proposer should address ALL Mandatory Requirements section items and provide, in sequence, the information and documentation as required (referenced with the associated item references).

The DHH Division of Contracts and Procurement Support will review all general mandatory requirements.

The DHH Division of Contracts and Procurement Support will also review the proposal to determine if the Mandatory Requirement Items (below) are met and mark each with included or not included.

The Proposer should adhere to the specification outlined in Section 10 of the RFP in responding to this RFP. The Proposer should complete all columns marked in ORANGE ONLY.

NOTICE: In addition to these requirements, DHH will also evaluate compliance with ALL other RFP provisions.

Proposal Section and Page number	PART ONE: MANDATORY REQUIREMENT ITEMS	For State Use Only	
		INCLUDED / NOT INCLUDED	DHH COMMENTS
	A.1 Provide the Certification Statement (RFP Appendix A) completed and signed, in the space provided, by an individual empowered to bind the Proposal to the provisions of this RFP and any resulting contract. ***The Proposer must sign the Certification Statement without exception or qualification.***	**Included / Not Included**	
	A.2 Provide a statement signed by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract containing the following guarantees that the proposal submitted shall become a contractual obligation and valid if a contract is awarded.	**Included / Not Included**	
	A.3 Warranty Against Cost Disclosure: The Proposer should warrant that it has not discussed or disclosed price or cost data with DHH prior to the opening of the proposal and that all price and/or cost data have been arrived at independently without consultation, communication or agreement with any competitor	**Included / Not Included**	
	A.4 Warranty Against Broker's Fees: The Proposer shall warrant that it has not employed any company or person other than a *bona fide* employee working solely for the Proposer or a company regularly employed as its marketing agent to solicit or secure the contract and should also warrant that it has not paid or agreed to pay any company or person other than the *bona fide* employee working solely for the Proposer as its marketing agent any fee, commission, percentage, brokerage fee, gifts, or any other consideration contingent upon or resulting from the award of the	**Included / Not Included**	

Proposal Section and Page number	PART ONE: MANDATORY REQUIREMENT ITEMS	For State Use Only	
		INCLUDED / NOT INCLUDED	DHH COMMENTS
	contract		

PART II: TECHNICAL PROPOSAL & EVALUATION GUIDE

The proposer should adhere to the specification outlined in Section §10 of the RFP in responding to this RFP. The Proposer should address ALL section items and provide, in sequence, the information and documentation as required (referenced with the associated item references and text and complete all columns marked in ORANGE ONLY.

A Proposal Evaluation Team, made up of DHH employees, will evaluate and score the proposal responses.

For those items in Part II that state (Included/Not Included) the proposals will be scored as follows:

a. **All items scored Included = 0 points**
b. **If 1-3 items are scored "Not Included" = -10 points**
c. **If 4-5 items are scored "Not Included" = -20 points**
d. **If more than 6 items are scored "Not Included" = -30 points**

Any contract resulting from this RFP process shall incorporate by reference the respective proposal responses to all items below as a part of said contract.

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B. Qualifications and Experience	**125**		
	B.1 Indicate your organization's legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g. publicly traded corporation). Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest. Indicate the name, title, mailing address and phone number(s) of the person DHH should contact regarding the Proposal. Provide your federal taxpayer identification number and Louisiana taxpayer identification number. Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provider the name and address of the local representative; if none, so state. If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.	**Included / Not Included**		
	B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales	**Included/Not**		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	of your organization's within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. I**nclude your organization's parent organization, affiliates, and subsidiaries.**	**Included**		
	B.3 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include an opinion of counsel as to the degree of risk presented by any pending litigation and whether pending or recent litigation will impair the Proposer's performance in a contract under this RFP. Also include any SEC filings discussing any pending or recent litigation. I**nclude your organization's parent organization, affiliates, and subsidiaries.**	**Included/Not Included**		
	B.4 Provide the following as documentation of the Proposer's sufficient financial strength and resources to provide the scope of services as required: Copies of financial statements for the past three (3) years preferably audited, including at least a balance sheet and profit and loss statement, or other appropriate documentation which would demonstrate to the Department, the Proposer's financial resources sufficient to conduct the project.	**Included/Not Included**		
	B.5 The Proposer shall provide DHH with full and complete information on the identity of each person or corporation with an ownership or controlling interest (5%+) in the Proposer's, or any contractor in which the Proposer has 5% or more ownership	**Included/Not Included**		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	interest. The Proposer 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 company and any of its contractors, 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.			
	B.6 Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. I**nclude your organization's parent organization, affiliates, and subsidiaries.**	**Include/Not Included**		
	B.7 If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report. Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. I**nclude your organization's parent organization, affiliates, and subsidiaries.**	**Included/Not Included**		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B.8 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports (as required in this Section) for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner. Include a statement that the parent organization will unconditionally guarantee performance by your organization of each and every obligation, warranty, covenant, term and condition of the Contract.	**Included/Not Included**		
	B.9 Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company.	**Included/Not Included**		
	B.10 Provide a narrative description of your proposed project team, its members, and organizational structure including an organizational chart showing the Louisiana organizational structure, including staffing and functions performed at the local level.	**5**		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B.11 Provide job descriptions for all contractor staff referenced in the RFP. Descriptions should indicate minimum education, training, experience, special skills and other qualifications for each staff position as well as specific job duties identified in the proposal. State job responsibilities, workload and lines of supervision.	15		
	B.12 Attach a personnel roster and resumes of key people who shall be assigned by you to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience. If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number. For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.	15		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B.13 Provide a statement of whether you intend to use subcontractors, and if so, the names and mailing addresses of the subcontractors and a description of the scope and portions of the work for each subcontractor with more than $100,000 annually. Describe how you intend to monitor and evaluate subcontractor performance. Also specify whether the subcontractor is currently providing services for you in other states and where the subcontractor is located. Subcontractors must be: • Independent of any MCO, PIHP, PAHP, PCCM, or other health care provider in the State in which they provide enrollment services. A subcontractor is not considered "independent" if it is an MCO, PIHP, PAHP, PCCM, or other health care provider in the state; or is owned or controlled by an MCO, PIHP, PAHP, PCCM, or other health care provider in the state • Free from conflict of interest. . A subcontractor is not considered free from conflict of interest if any person who is the owner, employee, or consultant of the subcontractor or has any contract with them: ➢ Has any direct or indirect financial interest in any entity or health care provider that furnishes services in the State ➢ Has been excluded from participation under title XVIII or XIX of the Social Security Act of 1965 as amended ➢ Has been debarred by any Federal agency or ➢ Has been, or is now, subject to civil money penalties under the Act.	**5**		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B.14 Provide a description your Corporate Compliance Program including the Compliance Officer's levels of authority and reporting relationships. Include an organizational chart of staff (marked as Chart B in your response) involved in compliance along with staff levels of authority.	**5**		
	B.15 Provide copies of any press releases in the twelve (12) months prior to the Deadline for Proposals, wherein the press release mentions or discusses financial results, acquisitions, divestitures, new facilities, closures, layoffs, significant contract awards or losses, penalties/fines/ sanctions, expansion, new or departing officers or directors, litigation, change of ownership, or other very similar issues, Do not include press releases that are primarily promotional in nature.	**10**		
	B.16 Describe your plan for meeting insurance requirements set forth in this RFP requirement	**Included/Not Included**		
	B.17 Provide the following information (in Excel format) based on each of the financial statements provided in response to item A.5: (1) Working capital; (2) Current ratio; (3) Quick ratio; (4) Net worth; and (5) Debt-to-worth ratio.	**10**		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B.18 Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. **Include your organization's parent organization, affiliates, and subsidiaries.**	**Included/Not Included**		
	B.19 If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. **Include your organization's parent organization, affiliates, and subsidiaries.**	**15**		
	B.20 Identify and describe any debarment or suspension, regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. I**nclude your organization's parent organization, affiliates, and subsidiaries.**	20		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	B.21 Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. **Include your organization's parent company, affiliates and subsidiaries.**	**Included/Not Included**		
	B.22 Submit at least two client references (minimum of two, maximum of five) for your organization and each subcontractor for work completed in the last 24 months.	**25**		
	B.23 Indicate the website address (URL) for the homepage(s) of any website(s) operated, owned, or controlled by your organization, including any that the Proposer has contracted to be run by another entity as well as details of any social media presence (*e.g.* Facebook, Twitter). If your organization has a parent, then also provide the same for the parent, and any parent(s) of the parent. If no websites and/or social media presence, so state.	**Included/Not Included**		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section C: Planned Approach to Project	**135**		
	Describe how you will set up operations capable of supporting the needs and meeting the requirements of the RFP beginning the effective date of the Contract. **C.1** Discuss your approach for meeting the implementation requirements and include: • A detailed description of your management philosophy including, but not limited to, the role of Quality Control, Professional Practices, Supervision, Distribution of Work and Communication Systems. • A detailed description of your project management methodology. The methodology must address, at a minimum, the following: o Issue identification, assessment, alternatives analysis and resolution; o Resource allocation and deployment; o Reporting of status and other regular communications with DHH, including a description of your proposed method for ensuring adequate and timely reporting of information to DHH project personnel and executive management; and o Automated tools, including use of specific software applications.	**25**		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	C.2 Provide a work plan for the implementation of the Enrollment Broker Process. At a minimum the work plan should include the following: • Tasks associated with your establishment of a "project office" or similar organization by which you will manage the implementation of the contract; • An itemization of activities that you will undertake during the period between the awarding of this procurement and the start date of the Enrollment Broker Contract and between the start date of the contract and enrollment of Medicaid recipients into a CCN. These activities shall have established deadlines and timeframes and as needed conform to the timelines established under this RFP for deliverables. • An estimate of person-hours associated with each activity in the Work Plan; • Identification of interdependencies between activities in the Work Plan; and • Identification of your expectations regarding participation by DHH and/or its agents in the activities in the Work Plan and dependencies between these activities and implementation activities for which DHH will be responsible. (In responding the Proposer shall understand DHH shall not be obligated to meet the Proposer's expectation.)	**25**		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	C.3 Provide a copy of the Work Plan in Microsoft Project or comparable project tracking software that includes the implementation activities, outlined in Section 4.0 of the RFP, along with the timeframes, person-hours, and dependencies associated with these activities. • Document procedures to protect the confidentiality of records in DHH databases, including records in databases that may be transmitted electronically via e-mail or the Internet. • A takeover/ transition plan which outlines the procedures and timelines to ensure continuity of services in the event of contract termination or award of contract to another vendor. The takeover/transition plan must include procedures that shall, at a minimum, comply with the stipulations listed in Section 6 of this RFP.	**40**		
	C.4 Provide a detailed outline of the training plan and orientation package for staff to ensure all key staff have a working knowledge of the Department, Medicaid including the Section 1115 Greater New Orleans Community Health Connections (GNOCHC) Medicaid waiver, and the individual programs.	**15**		
	C.5 Provide the process by which all temporary, permanent, subcontracted, part-time and full-time Contractor staff working on Louisiana Medicaid contracts who will have access to Protected Health Information (PHI) have had a national criminal background check prior to starting work on the contract.	**15**		
	C.6 Submit the process for securing an annual statement from all temporary, permanent, subcontracted, part-time and full-time Contractor staff working on Louisiana Medicaid Contracts that include an acknowledgement of confidentiality requirements and a declaration as to whether the individual has been convicted of a	**15**		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	felony crime or has been determined an "Ineligible Person" to participate in Federal Health care programs or in Federal procurement or non-procurement programs.			

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section D: Enrollment and Disenrollment	**400**		
	D.1 Provide a description of the proposed enrollment process and how it ensures the efficient and timely enrollment of Medicaid eligibles with a CCN and the GNOCHC Medicaid Waiver.	**90**		
	D.2 Describe the policies and procedures that address Choice Counseling including, but not limited to: • Description of the distribution process for providing Medicaid eligibles with information regarding CCNs and GNOCHC through enrollment kits, letters and/or member packets; • Previous successful experiences the company has with regard to Choice Counseling including the percentage of enrollees who pro-actively choose a health plan; • Types of community collaborations proposed be initiated for the purpose of ensuring successful communications with Medicaid eligibles regarding selection of a CCN or a GNCHC provider; and • Procedures that will be put in place to ensure Medicaid eligibles are able to receive timely access to one-on-one counseling, via telephone or in person upon request..	**50**		
	D.3 Description of the approach to meeting enrollment requirements, including, but not limited to: • Successfully meeting timeframes for enrollment processing;	**100**		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	• Establishment of a process that allows newborn CCN assignments to the mother's CCN, including but not limited to automatic assignment and plan change requests, as specified by DHH; and • Choice selection at 80% target percentage.			
	D.4 Describe the process for identification of Medicaid eligibles that fail to identify their CCN or GNOCHC choice within 30 calendar days from the postmark date that an enrollment form is sent.	**50**		
	D.5 Describe the process for ensuring that the auto-assignment process does not give preference to a specific CCN or GNOCHC provider.	**10**		
	D.6 Describe the procedure for timely processing of member-initiated disenrollment requests, including distinctions in requests "for cause" and "without cause". Description must also explain the process for requests from voluntary member populations.	**50**		
	D.7 Describe the procedure for timely processing of CCN or GNOCHC provider initiated requests for involuntary disenrollment, including member notification and ensuring care coordination until the effective date of the disenrollment.	**50**		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section E: Member Materials	**50**		
	E.1 The contractor shall provide Medicaid eligibles with information regarding CCNs or GNOCHC providers as applicable through enrollment kits, letters or member packets. Describe your distribution process.	**25**		
	E.2 Describe how you will fulfill Internet presence and Web site requirements, including: • Your procedures for up-dating information on the Web site; • Your procedures for monitoring e-mail inquiries and providing accurate and timely responses; and • The procedures, tools and reports you will use to track all interactions and transactions conducted via the Web site activity including the timeliness of response and resolution of said interaction/transactions.	**25**		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section F: Call Monitoring and Case Accuracy	**100**		
	F.1 The contractor must propose a call and case monitoring solution which will ensure excellent customer service, accuracy, consistency, and timeliness of enrollments. The solution must include: • The approach; • Measurement objective; • Monitoring frequency; • Sample size; • Result reporting; • Quality goals; and • Planned courses of action to be taken if the quality goal is not met.	**35**		
	F.2 Describe the comprehensive call and case monitoring solution to ensure staff follows proper protocol, policies, and procedures in the handling of inbound and outbound data and interactions with the client. (It must be submitted to DHH for approval prior to implementation.) The following must be included: • All telephone conversations with clients and end users must be captured to allow the contractor and DHH to review their contents. • Conversations must be retained for a minimum of six (6) months and be easily accessible by DHH in a manner that is acceptable to it, consistent with the requirements imposed on the State as a result of all court orders, consent decrees, corrective action orders, corrective action plans, and/or agreed settlements.	**35**		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	F.3 Describe the process which will provide DHH with the capability (including hardware, software, and training) to perform remote call and case monitoring to independently measure the quality of service being provided to clients, community resources, State workers and other service providers. This must allow DHH to perform call and case monitoring without notification to the contractor. Specifics must be included detailing how DHH will be able to conduct this monitoring.	**30**		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section G: Call Center - Customer Service	**165**		
	G.1 Detail the "user friendly" toll-free telephone line for enrollees, potential enrollees and their caregivers.	15		
	G.2 Explain the procedures that will be utilized to guarantee that ninety five percent (95%) of the calls received, Monday – Friday (excluding holidays), from 8:00 am-5:00 pm Central Time will be handled with no more that a two (2) minute wait. Calls not answered within two (2) minutes should be rolled over to an automatic attendant for messaging. This should include the reporting documentation that will be submitted to DHH.	15		
	G.3 Explain in detail the messaging system for after-hours calls received.	10		
	G.4 Describe the process for handling call received after-hours.	5		
	G.5 Describe the monitoring capabilities which will allow supervisors to audit the manner in which a call is processed as well as the efficiency of the operator.	5		
	G.6 Describe the monitoring capabilities which will allow instant determination of what mode an operator is in (available, on a call, completing after-work, etc.)	10		
	G.7 Describe the processes to be utilized for hearing impaired and non-English speaking members.	5		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	G.8 Describe and submit samples of reporting capabilities. These reports should include the following: • Length of time per call; • Number of calls waiting (or in queue); • Number of calls abandoned; • Number of calls per hour; • Number of calls waiting more than two (2) minutes; • Individual operator workload; • Number of calls received after hours; • Notification when a caller has been on hold for thirty (30) seconds so that no calls are waiting more than two (2) minutes for assistance. During the hold period the contractor shall have health informational messages on the line; and • Amount of call center downtime.	30		
	G.9 Describe the process for automatic routing of calls to the next available operator.	5		
	G.10 Describe the process of routing calls from specific sources (e.g., enrollees, potential enrollees, CCNs, GNOCHC providers) to a designated group of operators.	5		
	G.11 Describe the process which will ensure that all calls will be answered promptly (within three (3) rings coming out of hold messages) during normal business hours.	10		
	G.12 Describe the training / education that will be provided to the staff responsible for the toll-free number to ensure they have a working knowledge of the Medicaid services available.	10		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	G.13 Describe the process whereby DHH will be notified within thirty (30) minutes of awareness when there is difficulty with the phone lines.	10		
	G.14 Describe the process for monitoring the telephone lines for quality control.	10		
	G.15 Describe the process for performing a random sampling of 20 calls to different PCP practices within each CCN on a monthly basis to assist in validating CCN compliance with performance measures.	10		
	G.16 Describe the process utilized to record and track complaints; generate complaint and complaint resolution results; and record complaint activities.	10		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section H: Record Keeping Requirements	**50**		
	H.1 Describe the process that will be utilized to retain all books, records and other documentation relevant to the contract and funds expended there under for at least four (4) years after final payment or as prescribed in 45 CFR 74:53 (b) whichever is longer.	**50**		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section I: Reporting Requirements	**100**		
	I.1 Submit samples of reports that will meet the requirements outlined in section 2.2.6 of the RFP.	**100**		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section J: Transition Plan	**50**		
	J.1 Describe the process to ensure compliance with all requirements of the transition plan outlining the procedures and timelines to ensure continuity of services in the event of contract termination or award of contract to another vendor.	**50**		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section K: Fraud & Abuse	**25**		
	K.1 Describe your approach for meeting the program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Discuss your approach for meeting the coordination with DHH and other agencies requirement. Description must include processes for ensuring compliance with all requirements set forth in §2.4 Fraud and Abuse of the RFP.	**25**		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section L: Technical Requirements/Information Systems	250		
	L.1 Describe your approach for implementing information systems in support of this RFP, including: • Capability and capacity assessment to determine if new or upgraded systems, enhanced systems functionality and/or additional systems capacity are required to meet contract requirements; • Configuration of systems (e.g., business rules, valid values for critical data, data exchanges/interfaces) to accommodate contract requirements; • System setup for intake, processing and acceptance of one-time data feeds from the State and other sources, e.g., initial set of CCN enrollees, claims/service utilization history for the initial set of CCN enrollees, active/open service authorizations for the initial set CCN enrollees, etc.; and • Internal and joint (CCN and DHH) testing of one-time and ongoing exchanges of eligibility/enrollment, provider network if applicable, claims data (for identifying historic Medicaid provider relationships) and other data. • Provide a Louisiana Medicaid CCN-Program-specific work plan that captures: o Key activities and timeframes; o Meeting deadline for file transfer readiness to FI and CCNs; and o Projected resource requirements from your organization for implementing information systems in support of this contract.	40		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments

	• Describe your historical data process including but not limited to:
	  o Number of years retained;
	  o How the data is stored; and
	  o How accessible is it.
	
	The work plan should cover activities from contract award to the start date of operations.			

	L.2 Describe your processes, including procedural and systems-based internal controls, for ensuring the integrity, validity and completeness of all information you provide to DHH, CCNs, and GNOCHC providers. Additionally, describe how you will accommodate DHH-initiated data integrity, validity and provide independent completeness audits.	20		
	L.3 Describe in detail how your organization will ensure that the availability of its systems will, at a minimum, be equal to the standards set forth in the RFP. At a minimum your description should encompass: information and telecommunications systems architecture; business continuity/disaster recovery strategies; availability and/or recovery time objectives by major system; monitoring tools and resources; continuous testing of all applicable system functions, and periodic and ad-hoc testing of your business continuity/disaster recovery plan. Identify the timing of implementation of the mix of technologies and management strategies (policies and procedures) described in your response to (a), or indicate whether these technologies and management strategies are already in place. Elaborate, if applicable, on how you have successfully implemented the aforementioned mix of technologies and management strategies with other clients.	30		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	L.4 Describe in detail: • How your *key production systems* are designed to *interoperate*. In your response address all of the following: o How identical or closely related data elements in different systems are named, formatted and maintained: - Are the data elements named consistently; - Are the data elements formatted similarly (# of characters, type-text, numeric, etc.); - Are the data elements updated/refreshed with the same frequency or in similar cycles; and - Are the data elements updated/refreshed in the same manner (manual input, data exchange, automated function, etc.). o All exchanges of data between key production systems. - How each data exchange is triggered: a manually initiated process, an automated process, etc. - The frequency/periodicity of each data exchange: "real-time" (through a live point to-point interface or an interface "engine"), daily/nightly as triggered by a system processing job, biweekly, monthly, etc. • As part of your response, provide diagrams that illustrate: o point-to-point interfaces, o information flows, o internal controls and o the networking arrangement (AKA "network diagram") associated with the information systems profiled. o These diagrams should provide insight into how your Systems will be organized and interact with DHH systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with the Louisiana	30		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Medicaid CCN and GNOCHC Programs.			
	L.5 Describe your ability to receive, process, and update eligibility/enrollment, provider data, from the Department and its agents and transmit this data to CCNs and GNOCHC providers. In your response: • Explain whether and how your systems meet (or exceed) each of these requirements. • Cite at least three currently-live instances where you are successfully receiving, processing and updating eligibility/enrollment data and transmitting data to health plans and/or providers in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications. In elaborating on these instances, address all of the requirements in Section § 8. Also, explain how that experience will apply to the Louisiana Medicaid CCN Program and GNOCHC Program. • If you are not able at present to meet a particular requirement contained in the aforementioned sections, identify the applicable requirement and discuss the effort and time you will need to meet said requirement. • Identify challenges and "lessons learned" from implementation in other states and describe how you will apply these lessons to this contract.	30		
	L.6 Describe the ability within your systems to meet (or exceed) each of the requirements in Section §8. Address each requirement. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.	30		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	L.7 Describe your information systems change management and version control processes. In your description address your production control operations.	10		
	L.8 Describe your approach to demonstrating the readiness of your information systems to DHH prior to the start date of enrolling members with a CCN or GNOCHC provider. At a minimum your description must address: • CCN contract load and associated business rule • provider contract loads and associated business rules; • eligibility/enrollment data loads and associated business rules; • use of historic Medicaid claims data from Medicaid FI to determine historic Medicaid provider for auto assignment purposes..	15		
	L.9 Describe your reporting and data analytic capabilities including: • generation and provision to DHH of the management reports prescribed in the RFP; • generation and provision to DHH of reports on request; • the ability in a secure, inquiry-only environment for authorized DHH staff to create and/or generate reports out of your systems on an *ad-hoc* basis; and • Reporting back to CCNs and providers within the GNOCHC network.	15		
	L.10 Provide a detailed profile of the key information systems within your span of control.	5		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	L.11 Provide a profile of your current and proposed Information Systems (IS) organization.	5		
	L.12 Indicate how many years your IT organization or software vendor has supported the current or proposed information system software version you are currently operating. If your software is vendor supported, include vendor name(s), address, contact person and version(s) being used.	10		
	L.13 Describe the procedures that will be used to protect the confidentiality of records in DHH databases, including records in databases that may be transmitted electronically via e-mail or the Internet.	10		

Proposal Section and Page Number	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
	Section M: Emergency Management Plan	25		
	M.1 Describe the Disaster Recovery and Business Continuity Plan (DR/BCP).	25		

Proposal Section and Page Number	PART III: FINANCIAL	Total Possible Points	Score	DHH Comments
	Section N: Proposer's Financial Statements	25		
	N.1 Submit copies of the financial statements for the last three years, preferably audited, including at least a balance sheet and profit and loss statement, or other appropriate documentation which would demonstrate to the Department the Proposer's financial resources sufficient to conduct the project.	25		
	N.2 Provide the following as documentation of financial responsibility and stability: • a current written bank reference, in the form of a standard business letter, indicating that the Proposer's business relationship with the financial institution is in positive standing; • two current written, positive credit references, in the form of standard business letters, from vendors with which the Proposer has done business or, documentation of a positive credit rating determined by a accredited credit bureau within the last 6 months; • a letter of commitment from a financial institution (signed by an authorized agent of the financial institution and detailing the Proposer's name) for a general line of credit in the amount of five-hundred thousand dollars ($500,000.00).	**Included/Not Included**		

Proposal Section and Page Number	PART III: FINANCIAL	Total Possible Points	Score	DHH Comments
	Section O: Proposer Cost Analysis	500		
	O.1 Submit a detailed analysis of the per member per month (PMPM) cost and total cost for performance of tasks and methodologies of payment. Proposal must include all anticipated costs of successful implementation of all deliverables outlined. An item by item breakdown of costs must be included in the proposal. The itemized cost breakdown must include at the minimum the cost for the following: • Call center functions • Monitoring activities • Enrollment broker activities • Outreach and Education • Recruiting • Information Technology functions.	100		
	O.2 Total Cost Proposed The proposer with the lowest total cost shall receive 400 points. Other proposers shall receive points for cost based upon the following formula: **CPS = (LPC/PC)* 400** **CPS = Cost Proposal Score** **LPC = Lowest Proposal Cost of all proposers** **PC = Individual Proposal Cost** Total Cost = (PMPM x Total Member Months for CY1) + (PMPM x Total Member Months for CY2) + (PMPM x Total Member Months for CY3)	400		

APPENDIX H

CCN REQUEST FOR MEMBER DISENROLLMENT

ENROLLMENT BROKER REQUEST FOR PROPOSALS

CCN Request for Member Disenrollment

To: Medicaid CCN Enrollment Broker

From: _____

_____(CCN name) is requesting the member listed below to be disenrolled from for the following reason: _____

Print the Name of Member (Last, First, Middle Initial)	Birth Date	Medicaid ID Number or Social Security Number	Requested Disenrollment Date

☐ Member has demonstrated a pattern of disruptive, unruly, abusive or uncooperative behavior to the extent that enrollment in the CCN seriously impairs the organization's ability to furnish services to either the member or other members **and** the member's behavior is not caused by a physical or mental condition. (Attach separate narrative with additional information including measures taken by the CCN to correct the member's behavior prior to submitting the request for disenrollment)

☐ Member's utilization of services is fraudulent or abusive (e.g. member loans the CCN issued ID card to another person to obtain services). (Attach narrative with additional information including date of referral to Medicaid Program Integrity's Fraud Hotline)

☐ Member is placed in a long-term care nursing facility, ICF/DD facility, or becomes eligible for a Medicaid Home and Community-Based Services Waiver or hospice. Indicate which _____

☐ Member has died or is incarcerated. Date of death or incarceration _____

☐ Other _____

Signature: _____ Date: _____

The Louisiana Department of Health and Hospitals will determine if the CCN has shown a good cause to disenroll the Medicaid/CHIP member. The Enrollment Broker will give written notification to the CCN of the decision. Medicaid/CHIP members have the right to appeal disenrollment decisions and request a state fair hearing disenrollment to the Division of Administrative Law.

The CCN shall not discriminate against any Medicaid /CHIP member on the basis of their health status, need for health care services or any other adverse reason with regard to the member's health, race, sex, handicap, age, religion or national origin.

APPENDIX I

TRANSITION REQUIREMENTS

TRANSITION REQUIREMENTS

Introduction

Transition is defined as those activities that the EB is required to perform upon termination of the contract in situations in which the EB 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 EB 2) initiated by DHH, or 3) at the expiration of the contract period and any extensions.

General Turnover Requirements

In the event the contract is terminated for any reason, the EB shall:

- Comply with all terms and conditions stipulated in the contract, including continuation of services under the contract, until the termination effective date;

  and

- Comply with direction provided by DHH to assist in the orderly transition of equipment, services, software, leases, etc. to DHH or a third party designated by DHH.

Transition Plan

- In the event of written notification of termination of the contract by either party, the EB shall submit a Transition Plan within thirty (30) calendar days from the date of notification, unless other appropriate timeframes have been mutually agreed upon by both the EB and DHH. The Plan shall address the turnover of records and information maintained by the EB relative to the services provided to Medicaid recipients. The Transition Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the transition tasks. The Transition Plan must be approved by DHH.

- If the contract is not terminated by written notification as provided above, the EB shall propose a Transition Plan six months prior to the end of the contract period, including any extensions to such period. The Plan shall address the possible transition of the records and information maintained to either DHH or a third party designated by DHH. The Transition Plan must be a comprehensive document detailing the proposed schedule, activities, and

resource requirements associated with the turnover tasks. The Transition Plan must be approved by DHH.

- As part of the Transition Plan, the EB must provide DHH with copies of all relevant data, documentation, or other pertinent information necessary, as determined by DHH, for DHH or a subsequent EB to assume the operational activities successfully. This includes correspondence, documentation of ongoing outstanding issues, and other operations support documentation. The Plan will describe the EB's approach and schedule for transfer of all data and operational support information, as applicable. The information must be supplied in media and format specified by DHH and according to the schedule approved by DHH.

Transfer of Data

The EB shall transfer all data regarding services provided under this contract 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 EB. If DHH determines that not all of the data was transferred to DHH or the subsequent EB, 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 EB.

Post-Turnover Services

Thirty (30) days following transition of operations, the CCN must provide DHH with a Transition Results report documenting the completion and results of each step of the Transition Plan. Transition will not be considered complete until this document is approved by DHH.

If the EB does not provide the required relevant data and reference tables, documentation, or other pertinent information necessary for DHH or the subsequent EB to assume the operational activities successfully, the EB 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 EB also must pay any and all additional costs incurred by DHH that are the result of the EB's failure to provide the requested records, data or documentation within the time frames agreed to in the Transition Plan.

The EB 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..

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APPENDIX J

CCN ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

CCN ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

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 Appendix.

Enrollment Counseling

The Enrollment Broker will make choice counseling available to all eligible Medicaid individuals to provide assistance in selecting and enrolling into a CCN. Enrollment Broker staff will be available by telephone as appropriate to assist and provide choice counseling to CCN potential enrollees and enrollees. CCN potential enrollees and enrollees will be offered choice counseling as well as multilingual enrollment materials or materials in alternative formats, large print, and/or Braille when needed.

The Enrollment Broker's responsibilities subsequent to eligibility determination will include, but will not be necessarily be limited to, the following:

Educating the Medicaid eligible about CCNs in general, including the requirement to enroll in a CCN, the manner in which services typically are accessed under CCNs, the role of the PCP, the responsibilities of the CCN member, and his/her right to file grievances and appeals; and the rights of the member to choose any PCP within the CCN, subject to the capacity of the provider.

Educating the member, or in the case of a minor, the member's parent or guardian, about benefits and services available through CCNs.

Informing the member of available CCNs and outlining criteria that might be important when making a choice (e.g., presence or absence of the member's existing health care provider in a CCN's network, FQHC/RHC availability).

Identifying any barriers to access to care for the CCN members such as:

Necessity for multi-lingual interpreter services, and

Special assistance needed for members with visual and hearing impairment and members with physical or mental disabilities.

The Enrollment Broker will inform the Medicaid potential enrollee of all CCNs available in their GSA. The Enrollment Broker shall comply with the information requirements of 42 CFR §438.10 to ensure that, before enrolling, the potential enrollee receives, from the Broker, the accurate oral and written information he or she needs to make an informed decision. This information shall be provided in accordance with Section 1932 of the Social Security Act and 42 CFR §438.104; in an objective, non-biased fashion that neither favors nor discriminates against any CCN or health care provider.

The importance of early selection of a CCN will be stressed, especially if the Medicaid potential enrollee indicates priority health needs.

The Enrollment Broker will ensure that the enrollment process is accessible to eligible Medicaid potential enrollees and enrollees by mail, internet, toll-free telephone and face-to-face for Medicaid/potential enrollees and enrollees to call and ask questions or obtain information about the enrollment process and other information, including but not limited to, available CCNs in their GSA.

To assist Medicaid potential enrollees in identifying participating providers for each CCN, the Enrollment Broker will maintain and update weekly an electronic provider directory that is accessible through the Internet and will make available, (by mail) paper provider directories including any addendums provided by the CCN upon request.

The Enrollment Broker shall be responsible for distributing all enrollment materials to all eligible Medicaid enrollees by mail and/or other suitable means.

Voluntary Selection of a CCN

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.

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.

All members of a family unit will be required to select the same CCN unless extenuating circumstances warrant a different CCN. Such instances must be approved by DHH or its agent or designee.

Automatic Assignment into CCNs

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.

The Enrollment Broker's automatic assignment methodology shall be based on the following hierarchy:

- The member's previous CCN;
- Inclusion in the CCN provider network of the member's historic provider as identified by Medicaid claims history; If the provider with which the member has a historic provider relationship contracts with more than one CCN, the member will be assigned to a CCN with which the provider contracts, on a round robin basis.
- 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.
- 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.

  Beginning in October 2014, the CCN's quality measures will be factored into the algorithm for automatic assignment.

Neither the CCN-P Model nor the CCN-S Model will be given preference in making auto assignments.

If an entity is operating both a Prepaid and a Shared Savings Model within a GSA, it will be treated as one entity for any round robin auto assignment purposes with assignment made equally between the two.

Automatic Re-Assignment Into CCNs

- 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, tthe Enrollment Broker shall mail an enrollment packet to the Medicaid potential enrollee. The Medicaid potential enrollee may also elect to contact the Enrollment Broker to initiate the re-enrollment process prior to receipt of an enrollment packet.

- 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.

CCN Lock-In Period

The CCN members shall be enrolled for a period of twelve (12) months or until their next open enrollment period, contingent upon their continued Medicaid eligibility.

Following their initial enrollment into a CCN, members have ninety (90) days from the postmark date of the Notice of Enrollment to change CCNs for any reason.
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.

Voluntary Enrollees

Voluntary potential enrollees will be given a thirty (30) day choice period to choose a CCN or opt out of the CCN program.

The Enrollment Broker shall 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.

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.

Open Enrollment

The Enrollment Broker shall 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.

Each CCN member shall receive information and the offer of assistance with making informed choices about the CCNs in their area and the availability of choice counseling. The Enrollment Broker shall provide the member with information on the CCNs from which they may select. Each Medicaid enrollee shall be given sixty (60) calendar days to retain their existing CCN or select a new CCN.

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.

Suspension of and/or Limits on Enrollments

Each CCN must identify the maximum number of CCN members it is able to enroll and maintain under the Contract prior to initial enrollment of Medicaid eligibles. All CCNs will 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 CCN's Contract with DHH. 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.

CCNs will submit a quarterly update of its maximum capacity in each GSA. Each CCN will track slot availability and notify the Enrollment Broker when filled slots are within ninety (90) per cent of capacity. The CCN is responsible for maintaining a record of total PCP linkages of Medicaid members and provide this information quarterly to DHH.

The Enrollment Broker will notify DHH and the CCN when the CCN's enrollment levels reach ninety-five (95) per cent of capacity and will not automatically assign additional Medicaid eligibles.

In the event any 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 CCN; need to ensure continuity of care for the member; or determination of just cause by DHH. The Enrollment Broker shall evaluation each CCN's enrollment market share in each GSA for each calendar quarter and provider a written summary report to DHH within 15 days following the end of the quarter.

CCN Enrollment Procedures

Acceptance of All Eligibles

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.

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 CCN's Contract with DHH.

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.

Effective Date of Enrollment

Enrollment, whether chosen or auto-assigned, will be effective at 12:01 A.M. on the first (1st) calendar day of the month following the Member selection or Auto-Assignment, for those members assigned on or before the third (3rd) to last working day of a given month will be effective 12:01AM on the first (1st) calendar day of the month following assignment. For those members assigned after the third (3rd) to last working day in a given month, enrollment will be effective at 12:01 A.M. on the first (1st) calendar day of the second (2nd) month following assignment.

Newborn Enrollment

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.

The CCN should work with hospitals to report the births of newborns within twenty-four (24) hours of birth for enrolled members using DHH's web-based Request for Newborn ID system. If the mother has made a CCN and/or PCP selection, this information shall be reported to DHH who will transmit the information to the Enrollment Broker. If no selection is made, the newborn will be automatically enrolled by the Enrollment Broker into the mother's CCN. Enrollment of newborns shall be retroactive to the date of the birth.

Assignment of Primary Care Providers

Member Selects PCP during Enrollment

As part of the initial enrollment Medicaid application process, applicants may be given the option to indicate their preferred choice of CCN and PCP.

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.

The Enrollment Broker shall encourage the continuation of any existing satisfactory provider/patient relationship with their current PCP who is in a CCN.

The name of PCP requested by a new enrollee will be included in the Member File from the Enrollment Broker to CCN.

The CCN shall confirm the PCP selection information in a written notice to the member.

If no PCP is selected on the Member File received from the Enrollment Broker, the CCN will:

Contact the member, as part of the welcome packet, within ten (10) business days of receiving the Member File from the Enrollment Broker to assist the member in making a selection of a PCP.

The CCN shall inform the member that each family member has the right to choose his/her own PCP. The CCN may explain the advantages of selecting the same primary care provider for all family members, as appropriate.

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.

The CCN shall have written policies and procedures for handling the assignment of its members to a primary care provider. The CCN is responsible for linking all Medicaid enrollees to a primary care provider.

Automatic Assignments by CCN

The CCN is responsible for developing a PCP automatic assignment methodology in collaboration with DHH to assign an enrollee to a PCP when the enrollee:

- Does not make a PCP selection after a voluntary selection of a CCN; or

- Selects a PCP within the CCN that has reached their maximum physician/patient ratio; or

- Selects a PCP within the CCN that has restrictions/limitations (e.g. pediatric only practice).

Assignment shall be made to a PCP with whom, based on fee for service claims history or prior linkage, the member has a historical provider relationship. If there is no historical PCP relationship, the member shall be auto-assigned to a provider who is the assigned PCP for an immediate family member enrolled in the CCN plan. If other immediate family members do not have an assigned PCP, auto-assignment shall be made to a provider with whom a family member has a historical provider relationship.

If there is no member or immediate family historical usage members shall be auto-assigned to a PCP using an algorithm developed by the proposer, based on the age and sex of the member and geographic proximity.

The CCN and PCP automatic assignment methodology must be submitted, within thirty (30) days after the Contract is signed by the CCN, for approval by DHH prior to implementation. This methodology must be shared with subcontractors and members prior to enrollment.

The CCN shall be responsible for providing to the Enrollment Broker, information on the number of Medicaid member linkages and remaining capacity of each individual PCP of additional Medicaid member linkages n a quarterly basis.

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.

Effective the ninety-first (91st) day, the member may be locked into the assignment to the selected PCP for a period of up to twelve (12) months beginning from the original date the member was assigned to the CCN.

If a member requests to change his or her PCP with cause, at any time during the enrollment period, the CCN must grant the request.

The CCN shall have written policies and procedures for allowing members to select a new PCP, including auto-assignment, and provide information on options for selecting a new PCP when it has been determined that a PCP is non-compliant with provider standards (i.e. quality of care) and is terminated from the CCN, or when a PCP change is ordered as part of the resolution to a grievance proceeding. The CCN shall allow members to select another PCP within ten (10) business days of the postmark date of the

notice of termination of PCP to members and shall provide information on options for selecting a new PCP. The CCN shall have policies for accessing emergency/urgent care during this transition period. These policies and procedures shall be submitted within thirty (30) days from the date the CCN signs the contract with DHH.

The CCN shall notify the Enrollment Broker by close of business the next business day of a PCP's termination.

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.

Member Initiated Request

A member or his/her representative must submit an oral or written request to the Enrollment Broker to disenroll from a CCN. The member may disenroll for the following reasons:

For cause, at any time. The following circumstances are cause for disenrollment:

The member moves out of the CCN's designated service area;

The CCN does not, because of moral or religious objections, cover the service the member seeks;

The member requests to be assigned to the same CCN as family members;

The member needs related services to be performed at the same time, not all related services are available within the CCN and the member's PCP or another provider determines that receiving the services separately would subject the ember to unnecessary risk;

If DHH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a)(3).

The contract between the CCN and DHH is terminated; and

Other reasons including, but not limited to:

Poor quality of care;

Lack of access to CCN core benefits and services covered under the Contract;

Documented lack of access within the CCN to providers experienced in dealing with the member's healthcare needs; or

Any other reason deemed to be valid by DHH and/or its agent.

Without cause for the following reasons:

- During the 90 day opt-out period following initial enrollment with the CCN for voluntary members;
- During the 90 days following the postmark date of the member's notification of enrollment with the CCN;
- Once a year thereafter during the member's annual open enrollment period;
- Upon automatic re-enrollment under 42 CFR §438.56(g), if a temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or
- If DHH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a)(3).

The member (or his/ her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.

If the member's request for disenrollment is denied by the Enrollment Broker, the member can appeal directly to the State Fair Hearing process.

CCN Initiated Request

The CCN shall submit requests for involuntary disenrollment of a member that includes, at a minimum, the member's name, ID number, and detailed reasons for requesting the disenrollment utilizing the CCN Request for Member Disenrollment to the Enrollment Broker (See Appendix L). The CCN shall not request disenrollment for

reasons other than those stated in this RFP and the Contract. (See Appendix M – Guidelines for Member Disenrollment)

The following are allowable reasons for which the CCN may request involuntary disenrollment of a member:

A member's fraudulent use of the CCN's ID card. (e.g. The member misuses or loans the member's CCN-issued ID card to another person to obtain services.) In such cases the CCN shall report the event to the Medicaid Program Integrity Section; and

The member's behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the CCN seriously impairs the organization's ability to furnish services to either the member or other members and the member's behavior is not caused by a physical or mental health condition.

The CCN shall take reasonable measures to correct member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

The CCN shall promptly submit such disenrollment requests to the Enrollment Broker. The CCN shall not submit a disenrollment request at such a date as would cause the disenrollment to be effective earlier than forty-five (45) calendar days after the occurrence of the event prompting the request for involuntary disenrollment. The CCN shall ensure that involuntary disenrollment documents are maintained in an identifiable member record.

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 dispute resolution process with DHH that is established for CCNs.

DHH approved disenrollment requests shall be assisted and completed by the Enrollment Broker.

When the CCN requests an involuntary disenrollment, it shall notify the member in writing that the CCN is requesting disenrollment, the reason for the request, and an explanation that the CCN is requesting that the member be disenrolled in the month following member notification, or earlier if necessary. Until the enrollee is disenrolled by the Enrollment Broker, the CCN shall be responsible for the provision of services to that member.

The Enrollment Broker will provide written notice of disenrollment to the member and request that the member choose a new CCN. The notice shall include a statement that if

the member disagrees with the decision to disenroll the member from the CCN, the member has a right to file an appeal directly through the State Fair Hearing process.

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.

The CCN shall not request disenrollment because of the following:

- A member's health diagnosis;
- Adverse change in health status;
- Utilization of medical services;
- Diminished medical capacity;
- Pre-existing medical condition;
- Refusal of medical care or diagnostic testing;
- Uncooperative or disruptive behavior resulting from him or her special needs, unless it seriously impairs the CCN's ability to furnish services to either this particular member or other members as defined in this RFP; or
- The member attempts to exercise his/her rights under the CCN's grievance system, or attempts to exercise her/her right to change, for cause, the primary care provider that he/she has chosen or been assigned.

DHH Initiated Disenrollment

The Enrollment Broker will notify the CCN of the member's disenrollment due to the following reasons:

- Loss of Medicaid eligibility or loss of CCN enrollment eligibility;
- Death of a member;
- Member's intentional submission of fraudulent information;
- Member is incarcerated;;

- Member moves out-of-state;
- Member becomes Medicare eligible;
- Member is placed in a long term care facility (nursing facility or intermediate care facility for persons with developmental disabilities);
- Member is enrolled in a Medicaid home and community-based services waiver(HDBS) ;
- Member elects to receive hospice services;
- 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 member to unnecessary risk;
- The Contract between the CCN and DHH is terminated;
- The member loses Medicaid eligibility;
- The members eligibility changes to an excluded eligibility group;
- 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.

Disenrollment Effective Date

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.

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.

DHH, the CCN, and the Enrollment Broker shall reconcile enrollment/disenrollment issues at the end of each month utilizing an agreed upon procedure.

Enrollment and Disenrollment Updates

The Enrollment Broker will notify each CCN at specified times each month of the Medicaid eligibles that are enrolled, re-enrolled, or disenrolled from the CCN for the following month.

The Enrollment Broker will provide this notification through the ASC X12N 834 Benefit Enrollment and Maintenance electronic transaction.

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 by DHH. The Enrollment Broker shall have written policies and procedures for transmitting these updates the CCNs.

Weekly Reconciliation

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.

APPENDIX K

PROJECTED CCN MEMBER MONTHS

Projected CCN Member Months for Enrollment Broker Use in Making PMPM Price Projections

CCN Geographic Service Area	Mandatory Population	Voluntary Population	50% of Voluntary Population	Total Projected CCN Enrolled Population	CY 1 Projected MM	CY 1 Total MMs	CY 2 Projected MMs	CY 2 Total MMs	CY 3 Projected MMs	CY 3 Total MMs	CY 4 Projected MMs	CY 4 Total MMs	CY 5 Projected MMs	CY 5 Total MMs
GSA **A** (Regions 1 & 9)	249,953	12,671	6,336	256,289	7	1,794,020								
GSA **B** (Regions 2, 3, & 4)	304,652	15,443	7,722	312,374	5	1,561,868								
GSA **C** (Regions 5,6,7, & 8)	290,454	16,656	8,328	298,782	3	896,346								
				867,444		**4,252,233**	12	**10,617,515**	12	**10,829,865**	12	**11,046,462**	12	**11,267,391**

CY= Enrollment Broker Contract Year (8/1/XX through 7/31/XX)
MM = CCN Member Month

Member Month = Each month a Medicaid recipient is linked to a CCN. CCN. The total member months for a given month is equal to the number of CCN enrollees for that month.
Total Member Months = Total Number of Medicaid Recipients linked to CCNs X Total Number of Months in a Contract Year

ASSUMPTIONS:
Projecting that 50% of the voluntary population will be enrolled in a CCN with the other 50% opting to stay in fee-for-service Medicaid (Conservative estimate).
CCN enrollment will increase by 2% each contract year. (Conservative estimate). Applied to Years 2-5 of Contract.
GSA A'smembers come on board 1/1/12 (**7 months** of CY 1); GSA B members come onboard 3/1/12 (**5 months** of CY 1); GSA C members come onboard 5/1/12 (**3 months** of CY 1)