ORIGINAL

DHH - CF 1
Revised:2-08

AGREEMENT BETWEEN STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

CFMS: 689685
DHH: 055906

Office of Management and Finance

Agency # 305

Bureau of Health Services and Financing

AND

Automated Health Systems, Inc.

FOR

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

1) **Contractor (Legal Name if Corporation)** Automated Health Systems, Inc.	5) **Federal Employer Tax ID# or Social Security #** 25187646000 **(Must be 11 Digits)**
2) **Street Address** 300 Arcadia Court, 9370 McKnight Road	6) **Parish(es) Served** ST
City Pittsburgh **State** PA **Zip Code** 15237	7) **License or Certification #**
3) **Telephone Number** (412) 367-3030	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 #) N/A

9) **Brief Description Of Services To Be Provided:**
The Contractor shall provide a broad range of Medicaid administrative management functions including outreach, certification, recruitment of providers, linkage, service coordination, processing requests for exemption reporting and nurse helpline to comply with mandated requirements. CommunityCARE is a primary care case management (PCCM) program and KIDMED is a federally mandated program for Medicaid children under age of 21. This contract includes such duties as data downloads from the Fiscal Intermediary and capability of sorts, queries, ad-hoc reporting, updating and maintaining the current web site and hospice services as provided for in the contract. See Attachment B - Statement of Work.

10) **Effective Date** 05-01-2010	11) **Termination Date** 04-30-2012

12) This contract may be terminated by either party upon giving thirty (30) 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**
Contractor obligated to submit final invoices to Agency within fifteen (15) days after termination of contract
Invoices shall be submitted with appropriate reports/documentation. During contract year one (1), contractor will be paid a per member per month (PMPM) based upon the following: CommunityCARE - .81 PMPM, EPSDT - .79 PMPM, Nurse Helpline - 08 PMPM and a fixed monthly cost of $10,016 for Hospice services. During contract year two (2), contractor will be paid a PMPM based upon the following: CommunityCARE - .77 PMPM, EPSDT - .71 PMPM, Nurse Helpline - .08 PMPM and a fixed monthy cost of $10,254 for Hospice services. A retainage of 10% will be withheld from all approved invoices for surety of performance. Retainage will be released annually on determination of satisfactory job performance.

PAYMENT WILL BE MADE ONLY UPON APPROVAL OF:	**First Name** Sondra	**Last Name** Burns	
	Title Medicaid Program Manager 2		**Phone Number** (225) 342-4775

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

Attachment A: HIPAA Addendum
Attachment B: Statement of Work
Attachment C: Special Provisions
Attachment D: Invoice Format
Attachment E: Entire Agreement/Order of Precedence

Exhibit A: Disclosure of Ownership
Exhibit B: Multi Year Letter
Exhibit C: Out of State Justification
Exhibit D: Certificate of Authority
Exhibit E: Resume
Exhibit F: Board Resolution
Exhibit G: IT-10
Exhibit H Disaster Recovery Plan

The Statement of Work outlines contractual requirements for each of the following programs

- CommunityCARE,
- KIDMED; and,
- Hospice

1. OVERVIEW OF PRIMARY CARE CASE MANAGEMENT

1.1. Currently, the Louisiana Medicaid Primary Care Case Management (PCCM) program is called "CommunityCARE". The "KIDMED" Program is the screening component of the federally mandated Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program. It is the intent of the Department to blend these programs into a seamless and comprehensive Medical Home model in the context of a PCCM/EPSDT program

1.2. Management components of the PCCM program include responsibilities related to the medical home provider, medical home member, special projects, information technology, and contract management.

2. GOAL

2.1. The goal of the PCCM program is to improve the accessibility, continuity, and quality of care to members, while reducing the overall cost of care by strengthening the patient/physician relationship, encouraging appropriate care, and discouraging inappropriate or unnecessary utilization of care

2.2. Other goals include:

- Providing a "Medical Home" for Medicaid PCCM members,
- Promoting the educational and preventive aspects of health care to all Medicaid eligibles,
- Promoting the responsibility of the member to use health care resources appropriately;
- Supporting utilization of quality health care within the member's community when appropriate; and
- Informing all Medicaid eligibles of the Medicaid services and providers available to them.

3. DELIVERABLES

3.1. Provider Recruiting

3.1.1. The Contractor shall collaborate with the Department's Fiscal Intermediary (FI) to proactively recruit Primary Care Providers (PCPs) to participate in Medicaid and the PCCM Program, and shall recruit specialists to participate in the Louisiana Medicaid Program. Recruitment shall be statewide, including in areas where access to care may be an issue The Contractor shall also recruit PCP's and specialists across state lines in areas where residents generally seek medical care across state lines

3.1.2. The Contractor shall at a minimum of quarterly, evaluate the network of PCPs to identify areas of the state with low PCP participation rates, and report to the contract monitor

3.1.3. During the term of the contract, the Contractor will perform four (4) targeted outreach projects each year, outreaching to Medicaid and non-Medicaid providers, with the goal of increasing enrollment of PCPs in the CommunityCARE program. Non-Medicaid providers must enroll in Louisiana Medicaid before they are eligible to enroll as a PCP in the PCCM Program.

3.1.4. The Contractor shall, at a minimum of quarterly, evaluate the network to identify specialties with a low participation rate in Medicaid and report to the contract monitor. During the term of the contract, the Contractor will perform four (4) targeted outreach projects each year, with the goal of increasing enrollment of specialists in Louisiana. Medicaid

3.1.5. To facilitate network development and recruitment, the Department will provide the Contractor with an electronic listing of providers who are currently enrolled in the Louisiana Medicaid Program. While the Contractor can use this list as a starting point, the Contractor shall identify providers not currently participating in the Medicaid Program for recruitment into Medicaid. A key goal of the Medicaid Program is to expand the number of providers available to members in order to increase access and patient choice.

3.1.6. The Contractor shall initiate methods for recruitment of EPSDT providers to increase quality provider participation in the EPSDT program, with a focus on areas with limited access to providers The Contractor will develop strategies to encourage PCP's to provide necessary EPSDT screenings The Department's approval is necessary prior to implementation of guidelines and methods developed by the Contractor

3.1.7. The Contractor shall conduct a minimum of four (4) outreach projects to professional associations such as the state and local medical societies, the state and local AAP chapters, and the Association of Practice Managers in order to promote the PCCM program and the need for the medical home in Medicaid. Other outreach may be performed via website, direct mail, or other Contractor suggested activities approved by the Department

3.2. **Provider Certification and Orientation**

3.2.1. In conjunction with its recruiting efforts, the Contractor shall

- Provide an explanation of PCP responsibilities to each prospective PCP,
- Answer prospective providers' questions;
- Educate, promote, and facilitate providers' enrollment in the Medicaid Program if the provider is not currently enrolled as a provider by referring the provider to the Medicaid FI Provider Enrollment Unit, and assist providers to complete the Medicaid Provider Enrollment Application;
- Assist providers in completing the PCCM agreement;
- Assist providers in completing the enrollment process for electronic media claims (EMC) submission;
- Assist providers in enrolling in PCCM by obtaining signed PCP Program Agreements from providers agreeing to serve as PCP's;
- Track and report the reasons providers give for electing not to join the Program,
- Obtain and verify key PCP information outlined in the PCP application; and
- Use Medicaid provider identification numbers and National Provider Identifier (NPI)

3.2.2. The Contractor will provide for web-based provider enrollment, and is responsible for verifying information provided on enrollment agreements and ensuring that prospective PCP's meet all standards for participation. This includes, but is not limited to, verification of provider licensure and CLIA certificate, and ensuring that the staff's days/hours do not overlap at other locations.

3.2.3. As part of the certification process, the Contractor will call the provider's office after-hours in order to verify the provider's back-up arrangements exist as detailed on the enrollment agreement and meet the PCCM standards of participation.

3.2.4. In order to verify the provider's 24/7 coverage and hospital arrangements, the Contractor will contact other providers listed on the enrollment agreement as providing backup coverage in order to ensure that the backup provider(s) understands his/her obligation as a backup provider

3.2.5. The Contractor will also verify the provider's hospital admitting privileges with the hospital. If the provider does not have hospital admitting privileges, but instead has an agreement with another provider to admit his/her patients, the Contractor will contact the other provider to verify his/her agreement and understanding of his/her obligation as the admitting provider.

3.2.6. The Contractor shall schedule a site visit by the monitoring staff within ten (10) business days of receiving a complete and accurate enrollment document. The purpose of the site visit is to validate all information submitted on enrollment forms, to ensure that the new provider meets all standards for participation and site certification for enrollment as a provider. Office personnel shall be interviewed and their training and licensing, if any, verified.

3.2.7. An exit conference shall be held with the provider to discuss the findings and determine how and when any deficiencies will be addressed Efforts must be made to schedule the exit conference at a time when a physician is available to participate. A follow up letter listing identified deficiencies shall be sent within ten (10) business days of certification site visit to the provider for response on corrective actions taken.

3.2.8. The Contractor's PCP database will automatically track 90 day limit. If the deficiencies are corrected within 90 days, the Contractor will then reschedule the site certification and the enrollment process will continue. If the deficiencies are not corrected within 90 days, the Contractor will prepare and mail a letter to the provider advising him that the enrollment process has been cancelled If the provider contacts the Contractor after 90 days, the enroll process will start over from the beginning.

3.2.9. Upon verification of enrollment criteria and a satisfactory site visit, the Contractor will electronically notify the Department of the new enrollment

3.2.10. For Provider Enrollment Agreements, the Contractor will be responsible for the completion of the enrollment process which will include the assurance that all aspects of Enrollment Agreements are complete, accurate, and provide approval for enrollment.

3.2.11. The Contractor will coordinate the approval and enrollment of EPSDT Screening Providers with Department and Provider Enrollment staff. The Contractor will draft a Quality Assurance process for enrollments and submit to the Department for input and approval 60 days after contract begin date

3.2.12. Data compiled during site certification visits from field nurses is to be electronically transmitted to the Contractor's database within twenty-four (24) hours of the visit in order to ensure timely updating of files and transmission of information to the Department. The Contractor shall conduct on-site orientation for each newly enrolled PCP, addressing program requirements and standards for participation, no more than 10 days following approved enrollment.

3.3. Provider Certification and Orientation (EPSDT Screening Only)

3.3.1. In conjunction with its recruiting efforts, the Contractor shall:

- Provide an explanation of the EPSDT Screening Program and the responsibilities to each EPSDT screening provider;
- Answer prospective provider's questions;
- Educate, promote, and facilitate providers' enrollment in the Medicaid Program if the provider is not currently enrolled as a provider by referring the provider to the Medicaid FI Provider Enrollment Unit, and assist providers to complete the Medicaid Provider Enrollment Application;
- Provide for web-based EPSDT Screening Provider enrollment;
- Assist providers in completing the EPSDT Screening Provider agreement;
- Assist providers in completing the enrollment process for electronic media claims (EMC) submission;
- Validate all information provided on EPSDT Screening Provider enrollments and ensuring prospective EPSDT Screening providers meet all standards for participation, including, but not limited to:
    - Verification of equipment and supplies,
    - Verification of appropriate CLIA certificate;
    - Verification that provider's listed on enrollment documents as providing the EPSDT Screening services are enrolled in Medicaid.
- Assist providers in enrolling in EPSDT Screening Program by obtaining signed EPSDT Screening Program Agreements from providers agreeing to serve as EPSDT Screening Providers.
- Track and report the reasons providers give for electing to not enroll in the EPSDT Screening Program.
- Obtain and verify key EPSDT Screening Provider information outlined in the EPSDT Screening Provider application;
- Use Medicaid Provider identification numbers and National Provider Identifier (NPI); and
- Schedule a site visit by the monitoring staff within ten (10) business days of receiving a clean enrollment document. The purpose of the site visit is to validate all information submitted on enrollment forms, to ensure that the new provider meets all standards for participation and site certification for enrollment as a provider. Office personnel shall be interviewed and their training and licensing, if any, verified

3.3.2. An exit conference shall be held with the provider to discuss the findings and determine how and when any deficiencies will be addressed. Efforts must be made to schedule the exit conference at a time when a physician is available to participate. A follow up letter listing identified deficiencies shall be sent within ten (10) business days of certification site visit to the provider for response on corrective actions taken. Deficiency letters can be sent electronically to the provider but the letters must also be sent certified mail to ensure receipt.

3.3.3. If the deficiencies are corrected within 90 days, the Contractor will then reschedule the site certification and the enrollment process will continue. If the deficiencies are not corrected within 90 days, the Contractor will prepare and mail a letter to the provider advising that the enrollment process has been cancelled. If the provider contacts the Contractor after 90 days, the enroll process will start over from the beginning

3.3.4. Data compiled during site certification visits from field nurses is to be electronically transmitted to the Contractor's database within twenty-four (24) hours of the visit in order to ensure timely updating of files and transmission of information to the Department. Upon verification of enrollment criteria and a satisfactory site visit, the Contractor will electronically notify Department of the new enrollment.

3.3.5. The Contractor will be responsible for the completion of the enrollment process which will include the assurance that all aspects of Enrollment Agreements are complete, accurate, and provide approval for enrollment.

3.3.6. The Contractor must coordinate the approval and enrollment of EPSDT Screening Providers with the Department and Provider Enrollment staff;

3.3.7. The initial enrollment period of a newly enrolled EPSDT Screening Provider shall be for a period of six (6) months. A follow-up monitoring visit must be made between the fourth (4th) and sixth (6th) month after initial enrollment in order for the provider to obtain full approval of enrollment status. Thereafter, EPSDT Screening Providers will be monitored on an annual basis.

3.3.8. The contractor must conduct on-site orientation for each newly enrolled EPSDT Screening Provider, addressing program requirements and standards for participation, no more than ten (10) days following approved enrollment.

3.3.9. The Contractor will draft a Quality Assurance process for enrollments and submit to the Department for input and approval 60 days after contract begin date.

3.4. Provider Monitoring Site Visits

3.4.1. The Contractor will perform both a compliance review and an outcomes audit via an annual site visit and a records audit of all PCP and EPSDT-only providers.

3.4.2. The annual monitoring site visit will be scheduled to take place no more than 90 days, but no later than 30 days prior to the provider's certification date.

3.4.3. The Contractor will provide the contract monitor with a monthly report of which providers were monitored that month, along with results of the monitor. The report will also include which providers were due to be monitored, but were not, along with the reason the monitor did not occur, and what corrective action is being taken.

3.4.4. The purpose of the site visit is to determine program compliance including adherence to administrative procedures and clinical guidelines as well as quality assurance, and to initiate appropriate corrective action where compliance problems are found.

3.4.5. During the monitoring site visit, the Contractor will review the provider's enrollment agreement to verify that all information is still accurate. This includes verifying the back-up arrangements with the backup provider(s) as well as admitting arrangements with the hospital or admitting provider (if the PCP doesn't have his/her own privileges) Office personnel are interviewed and training and licensing verified. This licensing information will be entered into and verified through a credentialing software application implemented by the Contractor and approved by the Department. The Contractor will notify the Department of any provider with an invalid or restricted license. The Department shall have inquiry capability to the credentialing application.

3.4.6. Provider documentation procedures and recording forms are reviewed by the Contractor. Periodicity scheduling, missed appointments, screening and referral procedures are also reviewed

3.4.7. All equipment shall be checked for calibration dates where appropriate. A checklist shall be used to determine compliance with screening, program and staffing requirements

3.4.8. The records audit must be performed on a statistically valid random sample of members using claims history data.

3.4.9. Provider deficiencies/non-compliance will be handled according to established procedures detailed in the Provider Deficiency Flow Charts

3.4.10. Contractor must inform the Fiscal Intermediary Provider Relations Field Staff of an upcoming site certification visit and coordinate a joint visit, if appropriate, where policy and billing would be addressed by the FI's Provider Relations staff. These joint visits must be designated as such on the monitoring visit schedule submitted to the Department. Joint visits may be necessary at times other than site certification visits. An exit conference is held with the provider to discuss the findings and determine how and when any deficiencies will be addressed. If possible, the Contractor must schedule the exit conference at a time when a physician is available to participate. A follow up letter listing identified deficiencies is sent to the provider for response on corrective actions taken within ten (10) business days.

3.4.11. Provider monitoring should commence no less than thirty (30) days after the contract begins including activities regarding on site monitoring for enrollment and credentialing.

3.4.12. A schedule of the month's planned monitoring visits will be sent to the Department the last week of the preceding month. An updated schedule of the next week's planned monitoring visits will be sent to the Department the week prior to monitoring. In addition, a detailed weekly chart of all PCCM regional field nurse staff schedules will be sent to the Department within the week following the scheduling period. These schedules must reflect joint visits by the FI's Provider Relations staff and the Contractor, if applicable.

3.4.13. The Contractor will cooperate with the Department's Program Integrity section by supplying requested monitoring records of PCCM providers at the direction of the Department. Any monitoring results or other information that may warrant further investigation will be forwarded to the EPSDT or PCCM Program Manager at the Department.

3.5. Electronic Monitoring System

3.5.1. The Contractor shall have access to, as requested by the Department, all on-line information from the Fiscal Intermediary that will assist in monitoring the PCCM Program. This includes but is not limited to: timeliness of initial and periodic screenings, referral for conditions found in screenings and initiation of diagnosis, and treatment of other medically necessary services resulting from screenings.

3.5.2. The Contractor shall analyze monthly utilization reports produced by the FI and, in conjunction with the PCCM staff, determine the priority of nurse visits to counsel with providers who consistently exceed the average utilization by two (2) standard deviations above or below. Utilization reports are produced only on those providers with one hundred (100) or more members linked to them. Categories of services tracked on the monthly utilization report are pharmacy, office visits, lab/radiology, hospital admissions, referrals, emergency room visits and cost per member.

3.5.3. The Department will continue to carry out limited random audits of providers as well as monitoring the Contractor

3.5.4. Within thirty (30) days of the start of the contract, the Contractor will develop and must maintain, a PCCM/EPSDT Monitoring Manual which must include the complete monitoring process, instruments used, and available sanctions as approved by the Department.

3.6. Monitoring Accessibility of PCCM Providers

3.6.1. The Contractor shall implement, maintain and modify procedures for monitoring, on a monthly basis at a minimum, the accessibility of providers twenty-four (24) hours per day, seven (7) days a week, including holidays. At least once a month, each PCCM provider's telephone will be monitored after hours, on the weekend and/or a holiday. Non-compliant providers, once identified, shall be monitored more frequently.

3.6.2. The Contractor is to call the provider number, allow a minimum of five (5) rings, and if no answer, call the number again. If there is no answer on the second try, the provider is

considered not to have twenty-four (24) hour coverage. The Contractor shall also monitor for unacceptable messages. The monitor will walk-through the after-hours coverage from beginning to end, calling all numbers listed by the provider to ensure that a calling after-hours will be appropriately directed to live, on-call medical personnel. Providers who do not meet requirements will be contacted via telephone the next business day by the Contractor, and the Contractor will follow-up with written notification to the provider. In addition, the failed monitoring will be handled as a provider deficiency. Provider deficiencies/non-compliance will be handled according to established procedures detailed in the Provider Deficiency Flow Charts

3.6.3. Within thirty (30) days after the start of the contract, the Contractor must design and maintain an electronic application of provider phone monitoring with the data elements as outlined in the Department monitoring documents. The Contractor will design and produce a monthly management report subject to the Department's approval which details the findings, actions and types of responses. This report is to be printed in parish order, by provider, and shall be delivered ten (10) working days after the end of the month. The Contractor is not required to provide this report for EPSDT screening only providers.

3.6.4. No more than one week prior to each six month recertification and each annual monitor the Contractor will perform a "secret shopper" type call to the provider to validate that the provider is in compliance with the CommunityCARE appointment scheduling requirements. This includes contacting a provider for an appointment for a specific condition (to be determined by the Department) A failed monitor will be considered a deficiency and will be addressed as part of the monitoring visit.

3.7. Provider Education

3.7.1. The Contractor shall educate PCCM providers regarding issues such as how to make referrals, administrative processes, covered services, targeted areas of quality improvement, administrative changes, capabilities of data transfer between treating providers and PCP's and any other requirements when a need is identified by the provider, Contractor or the Department

3.7.2. The Contractor shall submit its provider education and training plan to the Department for approval within thirty (30) days of the start of the contract, and on an annual basis, and provide results of provider education activities through quarterly reports. The provider education and training plan shall include proposed training sessions and associated goals for each session, as well as how often they will occur, proposed dates and locations. The education and training plan shall also include a plan for offering training sessions to various provider types throughout various geographic regions in the state, and a list of educational materials that the Contractor shall develop and release to providers.

3.7.3. The Contractor's Provider Education and Training Plan must be implemented immediately upon provider enrollment, and at a minimum, incorporate the following components:

- Member Enrollment Process - The Contractor must inform PCP's about the process for enrolling potential members in the PCCM Program and with a PCP.

- Member Verification Requirements – The Contractor must inform providers that they are required to verify eligibility through the Medicaid Eligibility Verification System (MEVS), the Electronic Medicaid Eligibility Verification System (e-MEVS), or the Recipient Eligibility Verification System (REVS) PCP's will also be able to use the members panel lists via a secure online system to confirm Members linked to the provider for the month.

- General Medicaid Billing and Eligibility Verification – The Contractor shall refer the provider to Medicaid Fiscal Intermediary Provider Relations on any billing questions.

- Immunization Pay-for-Performance (P4P) Initiative – The Contractor shall inform PCCM providers of the P4P initiative including the availability of incentive provider payments and provide information on how the initiative works and how to enroll in the P4P initiative. The Contractor shall provide assistance to providers to enroll in the P4P initiative.

- EPSDT (Well Child) Screenings – The Contractor shall educate providers about the importance of conducting regular EPSDT (well child) screenings and the required content of those screenings, in compliance with the Provider Manual and Training material. This includes, but is not limited to: a complete physical examination and health history; vision and hearing screening, oral health screening, required immunizations, anticipatory guidance and referral. Additionally, the Contractor shall educate and facilitate providers' involvement in the Vaccines for Children Program and in the Louisiana Immunization Network for Kids Statewide (LINKS) immunization registry. The Contractor shall develop and distribute educational materials, which remind providers to place emphasis on scheduling and conducting EPSDT (well child) screenings based on the EPSDT periodicity schedule and guidelines, and establishing a recall system based on the periodicity schedule for well child screenings, including immunizations. The materials shall include information about participating in the Vaccines for Children Program and LINKS immunization registry.

- Referrals – The Contractor shall educate PCP's about their referral responsibilities and the process for using the online referral system set forth in the PCCM (currently CommunityCARE) Handbook and Training materials. The Contractor shall educate providers about steps to take when a member schedules an appointment without a referral.

- Complaint Process – The Contractor shall establish a complaint process within thirty (30) days of the start of the contract, and obtain approval from the Department. The Contractor shall educate providers about the process for making a complaint.

- Provider On-line Utilization Reports – The Contractor shall educate providers regarding use and analysis of the on-line Utilization Reports.

- Eligible Education Topics – The Contractor shall educate providers about how to handle members who go to the wrong provider office or who miss appointments frequently.

- Miscellaneous Topics – The Contractor shall provide training and produce educational materials on general topics including cultural sensitivity, health care disparities and treating members with special needs.

3.7.4. In addition to each of the specified provider training topics, the Contractor shall be available to conduct special informational and educational workshops, group meetings or training sessions for provider offices or specialty groups, upon request by the providers of Medicaid. The contractor shall conduct a minimum of two (2) per year

3.7.5. The Contractor shall coordinate its provider education activities with those conducted by other entities such as, but not limited to, the Disease Management Program Contractor, Administrative Service Organization (ASO) Contractor, Dental Contractor, Nurse Helpline Contractor, and the Fiscal Intermediary to ensure initiatives are not duplicative and similar information conveyed by multiple entities is consistent.

3.7.6. The Contractor shall provide ongoing communication with providers that includes developing and distributing all needed provider materials. The Contractor shall submit provider materials to the Department for approval at a minimum of thirty (30) calendar days prior to intended distribution or use. The Department will work to review materials within thirty (30) calendar days of receipt. The Contractor shall also post all provider materials on its website and recommend to the Department for approval other electronic methods of distribution, such as email. This Section provides a summary of the minimum types of required materials. In addition, the Contractor shall prepare and distribute additional provider materials, upon request by the Department.

3.7.7. The Contractor shall develop and distribute quarterly provider bulletins to communicate important updates and other helpful information. Four bulletins during the two (2) year contract period shall be targeted to 875 provider sites. Additionally, four bulletins during the two (2) year contract period shall be targeted to 2100 individual practitioners. The Contractor shall make the Provider bulletin available via surface mail and electronically on its website for providers to access.

3.7.8. The bulletins must include, but are not limited to, the following information:

- A summary of PCP Handbook updates;
- Recent policy and procedure clarifications,
- General Medicaid Program and PCCM Program updates (e.g., benefit changes, new service offerings, changes in populations served, etc),
- Answers to Frequently Asked Questions received by the Call Center; and
- Nationally accepted best practices.

3.7.9. The Contractor shall distribute provider bulletins or provider email update blasts, as requested by the Department.

3.7.10. The Contractor shall offer a minimum of two (2) web-based educational modules annually to providers on pertinent clinical and administrative topics approved by the Department. In addition, within sixty (60) days of the start of the contract the Contractor shall develop and implement a process for offering Continuing Education (CEs) for credit to the Medicaid medical professionals for Department approval. The Contractor shall track providers taking advantage of these educational opportunities and submit the related statistics in a monthly report.

3.7.11. The web-based provider education must be available to all Medicaid providers and not limited to PCCM providers

3.8. Annual Statewide Provider Training

3.8.1. The Contractor will participate in annual provider Training Workshops conducted by the Department Fiscal Intermediary The Contractor will set-up and man a booth at face-to-face workshops to assist in answering questions, promoting the PCCM programs, and distributing information and promotional items The Department may request certain promotional items be aimed at specific target outreach efforts such as promotion of referral assistance hotline numbers or reaching the adolescent population. The Contractor will be available to participate in any web-based or audio/video virtual workshops.

3.8.2. The Contractor will cooperate in training efforts by the Department to inform state and other agencies of the purpose of the PCCM programs and services available by the Contractor and through the PCCM programs. Training must either be coordinated by or approved by the Department.

3.9. Quality Management and Improvement

The Department is committed to continuously identifying opportunities for improvements and for developing and implementing strategies for quality improvement The Contractor must utilize a proven assessment methodology to monitor quality and implement a process of feedback and innovation. Within thirty (30) days of the start of the contract, a Quality Management system shall be developed which must include the following two (2) components at a minimum:

3.9.1.Quality Measurement

- The Contractor shall, identify and develop standards of quality, subject to Department approval, and using corresponding measures to determine if the prescribed standards are being met. The Contractor must identify in writing the required data elements and benchmarks and their detailed definitions, including the forms to be used and the specifications of detailed coding requirements. The Contractor shall measure quality indicators quarterly, using HEDIS, performance measures, but may use HEDIS-like measures if prior written approval is granted by the Department.

- The Contractor will collaborate with the Department in the design, development and implementation of procedures for the focused quality of care studies. The Contractor shall collect and compile the data necessary to conduct such focused quality of care studies (i.e., reviewing medical records, claims, administrative data, conducting special surveys, etc)

- These studies must be conducted in accordance with Department approved measures. The areas identified may include well visits, childhood immunizations, asthma, breast cancer and cervical cancer screening, diabetes, hypertension, access to primary care providers and lead screening The Contractor and the Department will collaborate on the topic of studies to be completed. Over the course of the contract, two (2) focused studies must be completed. The timeline for the studies will be determined in collaboration with the Department.

- Studies should be aimed at tracking and producing data, increasing rates and improving quality of care and health outcomes. After the baseline is established, the Department will set goals for improving rates

3.9.2. Quality Monitoring

- Within the first thirty (30) days of the start of the contract, the Contractor shall develop an ongoing system of data collection and reporting, subject to Department approval that provides a monitoring function through continual assessment of the quality of care being delivered against the quality measurement standards. The two categories of quality to be assessed are:

  - **Programmatic Quality**

    - The Contractor shall address aspects of quality of care that relate to policy level issues such as access to care, enrollment, retention, program costs, standards of care, and PCP change reasons related to quality of care.

    - Within the first thirty (30) days of the start of the contract the Contractor will develop and must maintain a PCCM Monitoring Manual which must include the complete monitoring process instruments used, and available sanctions as approved by the Department.

    - Within the first thirty (30) days of the start of the contract the Contractor shall develop a Department approved process, which ensures that continuous quality improvement actions for appropriate standards of care are being implemented based on monitoring findings. The Contractor will cooperate with the Department's Quality section by supplying requested monitoring records of PCCM providers at the direction of the Department.

  - **Provider Quality Profile Education and Support**

    - The Contractor shall utilize the on-line Provider Quality Profiles and in conjunction with the Department to determine the priority of nurse visits to counsel with providers who do not meet the expected threshold/benchmarks.. HEDIS measures tracked on the Provider Quality Profiles include, but are not limited to diabetes, asthma, well child visits, and breast cancer screenings. Contractor nurses must identify and educate providers who are unfamiliar with HEDIS definitions and measures.

    - The Department may request on-site chart reviews for use in additional analysis of Provider Quality Profile data for selected providers or selected HEDIS measures

3.10. Provider Resources

3.10.1. Provider Support Site Visits

- The Contractor shall visit each PCP provider site annually and, upon Department and/or provider request.

- In order to ensure proper credentialing of providers according to program standards as well as site certification for enrollment in the program, the Contractor will also use this opportunity to confirm/verify that the information submitted on the provider's enrollment agreement is still accurate. If the information has changed, the Contractor will advise the provider that a revised/updated enrollment agreement must be completed, and will follow-up with the provider until such time that the agreement is received by the Contractor and approved by the Department.

- Data compiled on support visits is to be automatically transmitted to the electronic PCCM provider tracking system within twenty-four (24) hours and reports produced within thirty (30) days of visit. Provider Support Site Visits may be scheduled in conjunction with Quality Monitoring Visits.

3.10.2. Program Support

- The Contractor shall provide program support which includes the following:

- Develop and implement guidelines that will further program objectives and increase progress toward national and state goals.

- Work with providers on issues including but not limited to increasing their understanding of program policy, increasing their screening and immunization rates, outreach for the LINKS immunization registry and for the PCCM Immunization Pay-for-Performance Initiative (including any future initiatives) and increasing use of program reports.

3.10.3. Provider Incentives

- Louisiana Medicaid currently has an Immunization Pay-for-Performance Initiative to provide incentive or bonus payments to PCCM providers to promote up-to-date immunizations of twenty-four (24) month old Medicaid eligibles. PCCM providers must be registered to receive these incentive payments, enrolled in and utilizing the Louisiana Immunization Network for Kids Statewide (LINKS) immunization registry, and enrolled in and utilizing vaccines from the Vaccines for Children Program

- The Contractor will provide the following during onsite monitoring/certification visits as well as at any other appropriate contact with PCCM providers:
  - Outreach and overview of the Pay-for-Performance Initiative;
  - Requirements for participation in the initiative; and
  - Assistance as needed with the registration process for the initiative

- The Contractor will be responsible for recruitment of non-participating PCCM providers into the P4P initiative

- As other provider incentive initiatives are developed by the Department, the Contractor will be responsible for outreach and promotion of those initiatives. Up to three (3) provider incentives initiatives should be anticipated over the life of the two (2) year contract.

3.11. Member Outreach

3.11.1. The Contractor will maintain, operate and adequately staff a system capable of providing outreach to members on a statewide basis. A detailed outreach plan must be submitted for Department approval within thirty (30) days of the start of the contract which incorporates local and statewide approaches. Member outreach should include a variety of strategies aimed at contacting, informing and offering, referring, and encouraging maximum utilization of EPSDT screening services. Member outreach will be a shared responsibility between the Contractor and the PCPs

3.11.2. The Contractor's Member outreach activities include but are not limited to:

- Education about the importance of having a primary medical home, including covered services, and when and how to access care through a PCP

- Education about the requirements for a referral to access providers other than the PCP.

- Follow-up with members under the age of twenty-one (21) who do not make an appointment with a PCP within 120 days of enrolling in the PCCM Program. This requirement relates to new enrollees under age twenty-one (21) for whom a physician claim has not been received within 120 days of enrollment in the PCCM

- Outreach to members and their families to encourage them to obtain EPSDT services, including identifying individuals not accessing EPSDT well-child screening services, and conducting direct outreach, such as appointment reminders to those individuals to encourage receipt of a screening exam which will result in increased screening rates.

- Development of a follow-up methodology for members who have not been screened in accordance with the EPSDT periodicity schedule to ensure increased screening rates.

- Monitoring and follow-up with members who have missed EPSDT screening and referral appointments.

- Implementation of creative strategies to assist members in scheduling and rescheduling EPSDT appointments and other referral appointments. After notification and appointment reminders have failed, strategies may include, but not be limited to home visits by Contractor outreach staff or nurses, and working with parish health departments, schools and other community agencies to reach families.

- Assistance to PCP's in setting up a recall system.

- Focused member outreach to the adolescent population required to increase well-care visits and immunization status of this population A detailed plan of the aggressive outreach strategies and activities, including a timetable, should be submitted to the Department for review and approval no later than three (3) months after the initiation of the contract.

- Implementation of strategies to outreach to members on the importance of adult preventive visits.

- Assurance that members' identified as needing a referral received the necessary diagnostic/follow-up services for the condition

- Development of eight (8) Department-approved, unique educational/program pieces produced throughout the two-year contract period.

- Development and implementation within thirty (30) days of the start of the contract, with Department approval, of a detailed Dental Screening Initiative for outreach to EPSDT members with the goal of increasing the dental screening rates for members under the age of twenty-one (21) years. The requirement is to increase dental screenings by 1% by the end of the first year of the contract, by 3% for the second year of the contract and by 5% in the third year of the contract, if extended Each measurement shall be compared to the prior year

- Increased screenings of other targeted Medicaid enrolled groups to be identified by the Department.

- The Contractor shall also maintain and modify as requested by the Department the procedures to ensure that participating screening providers are carrying out their screening outreach responsibilities as specified in their EPSDT Provider Enrollment Supplement and EPSDT (KIDMED) Provider Manual.

- Follow-up with members under the age of twenty-one (21) who are repeatedly non-compliant in keeping PCP and specialty appointments.

- Follow-up with members who have delivered but appear to have not received a post partum visit

- Education about the importance of planned pregnancies, prenatal care for pregnant women and other available services such as TAKE CHARGE and WIC.

- The Contractor shall establish a methodology to evaluate the provider referral system on a quarterly basis to confirm that specialists to whom members under the age of twenty-one (21) are being referred are accepting them as patients. For example, the Contractor shall track the percentage of referrals that resulted in a claim for the referred services as an indicator of access and review member complaints about specialty referrals.

- Agreements or sub-contracts with faith based organizations and other not-for-profit community organizations to assist with outreach activities as approved by the Department are encouraged.

- Member outreach will be a shared responsibility between the Contractor and the PCP

- The Contractor will work in coordination with the Department to develop and host an annual CommunityCARE/KIDMED Week for PCCM members and providers to showcase successful CommunityCARE/KIDMED outcomes.

3.11.3. All new Medicaid eligibles qualified for EPSDT services contacted and educated regarding the benefits of linkage to a PCP or ESPDT provider within sixty (60) days of Medicaid identification numbers being added to MMIS Recipient files.

3.11.4. The Contractor will be expected to develop a close working relationship through various outreach activities with the Department's eligibility staff and out stationed eligibility staff, Medicaid Application Centers, OCS Foster Care staff, Office of Youth Development staff, and Health Units to promote the benefits of the EPSDT screening program

3.11.5. The Contractor shall maintain and modify, as requested by the Department, existing procedures to accomplish member outreach objectives in an effective and efficient manner which yields the highest possible member acceptance and participation in EPSDT screenings Other methods for conveying information and innovative intervention strategies including specially designed brochures, telephone calls, and participation in health fairs are necessary, as well as coordinating PCCM week activities. See Linking Eligibles with Screening Providers section for information on requirements for non-PCCM members under age twenty-one (21) accepting EPSDT services.

3.11.6. The Contractor shall have access to the MMIS Recipient file. This will assist the Contractor in identifying new Medicaid eligibles for outreach activities. Release of member information shall be in conformity with Section 2080.18 of the State Medicaid Manual and 42 CFR 431.306, Section1902 (a) of the Social Security Act.

3.12. Memorandums of Understanding

The Contractor will interface and coordinate outreach efforts with statewide or local allied agencies, programs and organizations (who are not screening providers) having similar health objectives and serving Medicaid Eligibles under twenty-one (21) years of age. The Contractor shall develop agreements with allied agencies to participate in the dissemination of information on EPSDT, advocate proper utilization and act as a referral source. Some examples of these organizations are Early Steps, Head Start/Early Head Start, Agenda for Children and OPH Children with special Health Needs Program, Families Helping Families, March of Dimes, and :Louisiana Maternal and Child Health Coalition. Written agreements shall be established with major public agencies or organizations participating in these efforts Memorandums of Understanding with selected other organizations approved by the Department will be initiated. Procedures shall also be maintained and modified to monitor EPSDT outreach to foster children and Title IV-E adoptive children in each regional OCS office.

3.13. Member Complaints

Within thirty (30) days of the start of the contract, the Contractor will design, develop and implement, subject to the Department's approval, a process to handle member complaints in a manner compliant with federal, state and program policies and guidelines.

3.14. Correspondence

3.14.1. Every month approximately 13,000 new potential members are identified statewide. The Contractor is responsible for establishing and maintaining procedures for coordinating with the FI all facets of preparation, printing, and mailing of choice notices to members This choice notice currently is a two-sided legal length page which contains all of the required information. The Contractor will make modifications to improve the current choice notice. The mailing shall also include a provider listing based on the geographic proximity to the member's residence. The listing shall be updated each month to indicate changes in available PCPs or PCP restrictions, addresses, phone numbers etc. The notice shall also contain a multi-page member booklet. The multi-page member booklet should be printed using a durable (cover weight) cover and text weight interior. The bind can be perfect bind or saddle stitch, depending on the size of the document and the recommendations of the printer for sufficient binding. The final product should be 8 5 X 11 booklet or 9 X 12 booklet size Aesthetics and the target audience should be considered in the overall design.

3.14.2. Notices shall be produced and mailed at the direction of the Department. Additionally, the Contractor is responsible for the preparation, printing, and mailing of a confirmation

letter to all new members after choices/auto-assignments are made. Confirmation letters are also mailed to all members who have made PCP changes in a given month and must be mailed first class or with return mail option. Monthly confirmation letters are currently a two-sided letter sized page and include the business card sized PCP reminder card for members. This is a small card on which members can write their PCPs name and carry with them.

3.14.3. The Contractor is also responsible for preparation, printing, and mailing of Open Enrollment notices to all members once annually. The Contractor will also prepare, print, and mail letters to members who must select a new provider for reasons beyond the members' control, i.e., the PCP retires or withdraws from the Medicaid program. The letters shall be produced and mailed upon receipt of addresses with a timeline established by the Department on a case by case basis.

3.15. Linkage- Enrollment Broker Responsibilities

3.15.1. Linking PCCM Members with a Medical Home

- The Contractor shall be responsible for the input of data to update computer files on all PCCM members as well as PCCM providers. The Contractor's procedures for linking PCCM members shall be able to accommodate specific provider restrictions such as current practice only, specific age groups, and/or specific number of members, (i.e., females only, ages fourteen (14) and up; new patients for one age group and current patients for another age group). The Contractor must also be able to address special member needs such as identifying non-English speaking providers or providers who will accept medically fragile members. In linking PCCM members with PCPs, the Contractor shall ensure adherence to the Department policies for PCPs who elect to enroll as an EPSDT provider for their members under twenty-one (21) and those who elect to sub-contract for any or all ages of their EPSDT screening services.

3.15.2. Linking Non- PCCM Members with a Screening Provider

- The Contractor shall input, update, and have access to information, as requested by the Department, for determining whether or not new Medicaid Eligibles under twenty-one (21) years of age (including pregnant women under twenty-one (21)) have been linked to EPSDT services as part of the PCP linkage process or for non-PCCM members if they choose to be linked to an EPSDT screening provider. This determination shall be made at certification or re-certification of Medicaid Eligibles not already receiving screening services. Medicaid applicants and Eligibles may decline EPSDT screening services linkage. However, these services must still be explained and offered to Eligible individuals and families, at a minimum annually, preferably twice per year. A minimum of one (1) follow-up contact shall be made by the Contractor on all declinations to encourage the Eligible to reconsider and participate. The follow-up contact shall be made by telephone if possible. The Contractor is responsible for such follow-up.

- The Contractor shall link all non-PCCM members under age twenty-one (21) accepting EPSDT services with enrolled EPSDT medical, vision, hearing providers of their choice. Members will be linked to the same EPSDT provider for medical, vision, and hearing screening. All non-PCCM members identified through eligibility or other outreach activities shall be contacted by the Contractor within thirty (30) days (ten (10) days in infants). During the contact, the Medicaid applicant/Eligible shall be offered a choice of available enrolled EPSDT medical, vision, or hearing providers within reasonable access from the applicant/Eligible's home.

- An EPSDT form letter further explaining and confirming the selection of EPSDT screening provider(s) is sent by the Contractor to the member. This form letter advises the member to contact the EPSDT provider directly to request a screening appointment and gives the address(s) and telephone number(s) of the provider(s) selected by the member.

3.15.3. Exemption Requests

- The Contractor will provide for medical personnel of at least a Registered Nurse (RN) level to review the PCCM Exemption Request Forms, submitted by members (or the members' specialty care provider) requesting to be exempt from the PCCM program. The RN will then determine, based on appropriate medical protocol, PCCM program

policy, and federal regulations, whether the requests should be approved or denied. On approval, the Contractor will prepare and mail correspondence to the member and/or requesting provider advising of the approval. If the request is denied, the Contractor will forward the information to the Department for final resolution. Exemption requests shall be processed and a determination made within three (3) business days of the receipt of the request.

3.15.4. Disenrollment of Member by PCP

- PCP change requests may be initiated by either the PCP or the member. Change reasons for both are established by the Department in accordance with federal regulations, program policy and reporting requirements. The Contractor must track and report change request reasons to the Department monthly. The Contractor will be responsible for determining whether requests should be approved or denied. Change (unlink) requests made by the PCP for medical reasons (as opposed to administrative reasons) must be reviewed by medical personnel of at least a Registered Nurse (RN) level. The Contractor will respond with a written acknowledgement of receipt of the request, as well as approval or denial of the request. The response will be made via email or fax at a minimum. Within three (3) business days of receipt of an approved disenrollment request, a choice letter shall be mailed to the Contractor to allow the member to choose a new PCP. The change should be processed for the earliest possible month. Telephonic contact to the member is permitted.

3.15.5. Conditions that enrollment brokers must meet.

- State expenditures for the use of enrollment brokers are considered necessary for the proper and efficient operation of the State Plan and thus eligible for FFP only if the broker and its subcontractors meet the following conditions:

- Independence. The broker and its subcontractors are independent of any MCO, PIHP, PAHP, PCCM, or other health care provider in the state in which they provide enrollment services. A broker or subcontractor is not considered "independent" if it-
  - Is an MCO, PIHP, PAHP, PCCM or other health care provider in the state;
  - Is owned or controlled by an MCO, PIHP, PAHP, PCCM, or other health care provider in the state; or
  - Owns or controls an MCO, PIHP, PAHP, PCCM, or other health care provider in the state.

- Freedom from conflict of interest. The broker and its subcontractor are free from conflict of interest. A broker or subcontractor is not considered free from conflict of interest if any person who is the owner, employee, consultant of the broker or 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 in which the broker or subcontractor provides enrollment services;
  - Has been excluded from participation under title XVIII or XIX of the Social Security Act of 1965 as amended (hereinafter "the Act");
  - Has been debarred by any Federal agency; or
  - Has been, or is now, subject to civil money penalties under the Act.

- Approval. The initial contract or memorandum of agreement (MOA) for services performed by the broker has been reviewed and approved by CMS. [67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

3.16. EPSDT Screening Administration

The Contractor, through access to the electronic scheduling and tracking system, will be responsible for scheduling initial and periodic screenings with the designated screening providers upon request, ensuring screenings are performed within required time frames and tracking of all screening services.

3.16.1. Maintaining Updated Files of Members and Providers

- Information will be maintained and updated in the electronic system for all EPSDT linked members whether linked in the PCP linkage process or the non-PCCM process. Members who have previously received EPSDT screening services shall also be identified.

3.16.2. Scheduling Initial Screenings

- The Contractor shall have access to and input data into the scheduling system. This system helps to ensure that Medicaid Eligibles under age twenty-one (21) years accepting EPSDT screening services are scheduled for initial medical, vision, hearing and dental screenings (if age appropriate) within the required time limits.

- At least eighty-five (85) percent of the members accepting services shall be scheduled for an initial medical, vision, hearing and dental screening within the time limits given below (time limits are based the date the Contractor is notified by the FI of new Medicaid eligibles under 21 years of age):

  - Newborns immediately(within two (2) weeks of birth)
  - Children one (1) month to three (3) years of age within forty-five (45) days of the date of contact
  - Children three (3) to six (6) years of age-within sixty (60) days of the date of contact
  - Children six (6) through twenty (20) years of age within one hundred and twenty (120) days of the date of contact

NOTE: The date of contact is the date the Medicaid Eligible or Eligible's parent/guardian is contacted by (or contacts) the Contractor regarding screening services.

3.16.3. Scheduling Periodic Screenings

- The Contractor shall have access to paid claims screening information in order to ensure that screenings are scheduled in accordance with the required medical, vision and hearing screening periodicity schedules delineated in the EPSDT Provider Manual.

- The Contractor may require EPSDT medical screening providers to schedule all screenings in the first year of life for infant Eligibles after the initial screening because of the short time span between required screenings for infants. Providers may schedule periodicity appointments after the initial screening or request the Contractor to do this on members one (1) year or older. Standard procedure shall be developed for the screening provider to notify promptly the Contractor of the appointment date or vice versa. These procedures shall include use of the required interactive online appointment scheduling application as well as utilizing the universal EPSDT screening claim form for this purpose, or HIPAA mandated forms when appropriate.

- The Contractor shall have access and input to the electronic screening appointment scheduling tickler system. Medicaid eligibles shall be reminded of scheduled medical, vision, hearing and dental screenings. The Contractor shall establish a reasonable timetable for reminder letters, generated by the Contractor's system, to be sent out and telephone contacts or other identified efforts to successfully contact members for whom appointments have been scheduled.

- Providers may also perform inter-periodic screenings as provided in the EPSDT Manual.

3.16.4. Rescheduling Missed Screening Appointments

- The Contractor shall have access to and input data to the electronic screening appointment tickler in order to assist members or providers, at their request, to reschedule missed screening appointments.

- The Contractor shall assist, upon request from the member or provider, to reschedule any missed medical, vision, hearing and dental screening appointment and document same.

3.16.5. Tracking Screening

- The Contractor shall have access to paid claims screening information in order to verify that scheduled medical, vision, hearing, and dental screenings actually took place within required time limits. This may be accomplished by the provider reporting on the universal claim forms submitted or by the Contractor contacting the Medicaid Eligible or screening provider. Verification using claims is not recommended on children under two (2) years of age. If verification is not received by claim forms, the Contractor shall contact the Medicaid Eligible or screening provider directly for

verification and tracking purposes All screenings shall be verified within sixty (60) days of the scheduled screening on children two (2) years to six (6) years of age and ninety (90) days on older children

- The Contractor shall develop and implement within the first six (6) months of the contract, with assistance and approval of the Department, an online and interactive "Screenings Due" function to allow screening providers the ability to view the screening history of linked Members including when screenings are due.

3.17. EPSDT Healthcare Coordination

3.17.1. Service Coordination

- The Contractor will be responsible for service coordination on all Medicaid eligibles who received medical, vision, hearing, and dental screening services and were found to need further diagnosis, initial treatment or other medically necessary services. At a minimum, these services shall include those described below:

  - **Scheduling Diagnosis and Treatment**
    The Contractor shall ensure that medically necessary follow-up and other health related services are scheduled and initiated within sixty (60) days of the medical, vision or hearing screening on at least seventy-five (75) percent of the members screened with abnormal screening results

    The Contractor shall have access to paid claims screening information which identifies Medicaid eligibles with medical, vision, or hearing results indicating a condition or abnormality requiring follow-up. The Contractor shall be capable of giving appropriate referral resource information to providers and members with abnormal screening results requiring follow-up for further diagnosis and treatment, initial treatment or other services. Screening providers shall coordinate referrals for further diagnosis and treatment with the PCP in accordance with PCCM/EPSDT policy. The Contractor shall be responsible for providing information regarding these referrals as requested by the PCP Information regarding referrals shall ensure freedom of choice of providers.

    The Contractor shall maintain knowledge of community based health care resources available to assist members in obtaining needed services not covered by Medicaid

    Specific service coordination activities related to scheduling and notifying Medicaid eligibles and providers of appointments for further diagnosis, initial treatment and other services shall be fully described in the proposal.

    The Contractor shall provide education to members on how to properly utilize services of screening providers, other health care providers, emergency room services, and emphasize patient compliance with physician instructions, federal and state regulations

    The Contractor shall develop, within thirty (30) days of the start of the contract, with assistance and approval from the Department, an on-line appointment reminder system where the provider may opt to enter their request for an appointment reminder letter to be generated and mailed to the member by the Contractor. The online appointment reminder system should be part of the CommunityCARE/KIDMED website.

  - **Tracking Diagnosis and Treatment**
    The Contractor shall have access to paid claims information which verifies that further diagnosis and treatment, initial treatment and other medically necessary services took place within required time limits.

  - **Rescheduling Missed Diagnosis or Treatment Visits**
    The Contractor will be responsible for rescheduling missed appointments for medically necessary services resulting from screenings as part of the service coordination responsibilities.

The Contractor shall reschedule missed diagnosis treatments and document same

The Contractor shall ensure that at least sixty-five (65) percent of the missed appointments for further diagnosis initial treatment or other services are rescheduled and services initiated within thirty (30) days.

The Contractor will not be responsible for scheduling appointments for ongoing medical treatment on members after treatment is initiated.

Transportation Management

The Contractor will be responsible for determining the need for transportation services, offering assistance with transportation and arranging Medicaid covered transportation services via contact with the dispatch contractor, if needed, for Medicaid eligibles to receive EPSDT medical, vision, hearing, and dental screening services and for the first referral appointment for members identified as needing further diagnosis, initial treatment or other medically necessary services resulting from EPSDT screenings Tasks related to transportation management include:

- Receiving telephone requests for transportation for Medicaid eligibles under age twenty-one (21) years,
- Screening transportation request, determining if free resources are available and determining eligibility for Medicaid covered transportation according to Medicaid policy;
- Assist with transportation for Medicaid eligibles under twenty-one (21) years old via contact with dispatch contractor;
- Documenting transportation requests according to Department procedures, and
- Referring scheduling problems and complaints between Medicaid eligibles and transportation providers to Department transportation program staff.

3.17.2. Coordination with Other Service Programs

- The service coordination system shall be capable of coordinating EPSDT screening, further diagnosis, initial treatment and targeted case management services with other agencies or health professionals

- The Contractor shall work closely with primary case managers and mental health rehabilitation services providers in public and private agencies to schedule and coordinate periodicity screening appointments and other medically necessary services resulting from screening.

3.18. Member Education

3.18.1. The Department's goal for member education is to increase members' understanding of the Medicaid Program and the PCCM Program (particular attention must be given to minimizing the disruption of existing provider and member relationships during the enrollment process)

3.18.2. The Contractor will conduct member educational activities in coordination with other parish or area activities, which would reach members in each parish of the state. Examples may include but are not limited to participation in health fairs, brochures, videos, community meetings, and other similar methods. Consideration must be given to meeting the educational needs of non-English speaking members, functionally illiterate members, and visual and hearing impaired members.

3.18.3. The Contractor shall develop education aimed at helping members become empowered to be:

- More effective partners in their healthcare;
- Better able to understand the appropriate selection and use of needed health care resources;
- Better able to identify appropriate measures of preventive care and to seek the appropriate attention before their health reaches crisis level;
- Better at appropriately utilizing the health care system, making and keeping scheduled appointments, as appropriate, and
- Compliant with medical recommendations.

3.18.4. The Contractor shall develop and maintain member education programs designed to provide members with clear, concise and accurate information about the PCCM Program All written material provided to members or potential members will be at or below a fourth (4th) grade reading level

3.18.5. The Contractor shall submit its member education plan to the Department for approval on an annual basis, and provide results of member education activities through quarterly reports

3.18.6. The Contractor will produce and distribute educational materials with the Department, so that initiatives are not duplicative and so that similar information conveyed by multiple entities is consistent. The Contractor will coordinate outreach efforts including printing and mailing materials

3.19. Member Educational/ Program Material

3.19.1. The Contractor will produce, and mail to members a total of eight (8) unique pieces of educational/program materials over the life of the two year contract. Materials must meet Departmental approval and should inform members on topics such as covered services, access to providers, health or wellness promotion, healthy lifestyle practices, preventative adult services and the five disease/quality areas (breast cancer, cervical cancer, asthma, diabetes and hypertension). Member information shall be available in English, Vietnamese and Spanish, as well as for the visually and hearing impaired populations in a format that is easily read and understood by members and potential members.

3.19.2. All educational material shall be accessible on the CommunityCARE/KIDMED website Educational material shall be of the following specifications: 1 page front and back, a minimum of four color; size must be a minimum of 8.5 by 11 80# text weight minimum; expected volume is 1 per household. Member educational/program material includes but is not limited to educational materials about preventive adult services and the management of common chronic diseases.

3.19.3. The Contractor shall revise, produce and distribute to all PCCM members an outreach card which tells the member about the PCCM Program and how to access services through the Program. The Contractor may submit for consideration, alternative designs, but the existing card will need to be revised to comply with program requirements The card is to be multi-color, on coated paper, and to be approved by the Department 250,000 outreach cards shall be produced annually and distributed as follows: mail to PCCM members upon request; drop shipped upon request of the Department to BHSF Offices, OFS Offices, OCS Parish Offices, and/or Medicaid providers.

3.19.4. Within the first thirty (30) days from the start of the contract, the Contractor shall produce and distribute a multi-page PCCM/EPSDT member booklet and a choice notice to all new PCCM members each month. . This member booklet shall also be mailed during open enrollment to any PCCM member who did not receive a booklet in the past one (1) year; Alternate designs will be considered by the Department;

- For non-PCCM members who are under twenty-one (21) years of age, the Contractor shall create and distribute a separate brochure which must include information on all Medicaid services available for all EPSDT eligible members. The brochures shall be in English, Vietnamese, and Spanish. In addition, information must be available for the visually impaired.

- The Contractor must distribute to providers and other outreach locations informational materials, such as pamphlets, brochures, posters and videos to inform families of non-PCCM members under the age of twenty-one (21) years of the importance of well-child care and EPSDT services.

3.19.5. The Contractor shall develop and distribute to providers, 1500 posters, per subject matter and 1000 volumes of media with capability to download for additional sites. The subject matter must cover eight (8) individual topics using technologically current media with possible subjects to include appropriate use of the Emergency Room, preventative physical and dental care, childhood obesity and long term health effects of childhood obesity, nutrition and exercise for good health, pre-natal care, appropriate use of prescribed and over the counter medication, early signs/symptoms of behavioral health issues, Contact List (ways to contact service providers i.e., transportation, Nurse

Helpline, primary physician) and others as appropriate. Department approval is required prior to distribution

3.19.6. The Contractor shall print and distribute simple EPSDT brochures to be used for ongoing education for statewide eligibility staff, PCCM providers, and public agencies as requested. The existing brochure consist of 1 page double sided, 8.5 X 14, full colored, glossy and multi-lingual brochures with separate brochures for English, Spanish and Vietnamese. The existing brochure must be revised to comply with program requirements. The brochures must be approved by the Department. Alternate designs will be considered by the Department

3.19.7. EPSDT material must include the following, at a minimum:

- How and when to utilize services;
- The importance of scheduling and keeping appointments, including the periodicity schedule;
- The importance of EPSDT (well child) screening and follow up as recommended.
- The content of comprehensive EPSDT services, including immunizations, physical, health history, laboratory, including lead screening, hearing and vision screening, health information and what to expect during the well-child visit;
- The process for receiving assistance to make appointments for EPSDT, if needed;
- Educational materials addressing issues specific to members with special needs, for example, materials about HIV/AIDS and developmental disabilities;
- Educational materials regarding planning a healthy birth, including the importance of folic acid, smoking cessation, alcohol reduction or abstinence with respect to promoting healthy births;
- Promotional materials such as brochures and posters; and
- Program bulletins that notify members of significant policy or Program changes at least thirty (30) days prior to the effective date of the change.

3.19.8. Written information detailing all available Medicaid services as well as more specific EPSDT information such as a periodicity schedule, how to obtain covered transportation services and the Friends and Family Transportation program will be mailed to each non-PCCM member that accepts EPSDT screening linkage; and

3.19.9. The Contractor shall forward to the Department for review and approval prior to use, provider marketing materials such as direct mailings and correspondence, brochures, leaflets, flyers, presentation materials used by marketing representatives, and advertisements in newspapers, magazines, radio, television, billboards, and the yellow pages, media materials mailed to or aimed at Medicaid eligibles and any materials developed by providers that mention eligibles, Medicaid or Title XIX. The Contractor shall notify provider of decision regarding their marketing materials.

3.20. Member Quality Materials

3.20.1. The Contractor shall develop, produce, print and mail, upon request and approval from the Department, member education materials aimed at disease management and improving the quality of care for PCCM members. Educational materials will be necessary on a statewide basis.

3.20.2. A total of 150,000 pieces of educational materials to address five disease/quality areas (breast cancer, cervical cancer, asthma, diabetes and hypertension) will be distributed, during site certification and annual monitoring, to providers during the first two years of the contract. The Contractor is required to submit a quarterly report identifying providers to whom these materials were distributed.

3.20.3. The Contractor shall produce large and small posters for use in providers' waiting rooms and exam rooms Posters will be developed to provide educational material for members on at least five (5) separate disease/quality areas. A minimum of 5 posters must be produced annually. These educational materials should be available in English, Spanish and Vietnamese.

3.20.4. The Contractor shall produce pocket guides on the 5 specific disease/quality areas as directed by the Department for use by provider staff. The pocket guide will be a 4-inch X 6-inch laminated pocket guide containing information that coincides with disease/quality areas for mailing to providers at the request of the Department.

3.20.5. The Contractor shall produce promotional items, such as magnets, on specific disease/quality topics as directed by the Department. Promotional items shall be produced in the following quantities. Asthma 15,000; Diabetes 15,000; Hypertension 25,000; Breast Cancer Screenings 30,000, and Cervical Cancer Screenings 65,000

3.20.6. The above are examples of items requested by the Department. Alternate formats and materials may be substituted as requested or approved by the Department.

3.20.7. Revisions will be made as needed to maintain compliance with requirements of the Balanced Budget Act of 1997, changes in Federal and state Medicaid regulations, or program policy changes.

3.21. Member Resources

3.21.1. PCP Directory

- The Contractor shall develop and maintain a current PCP Directory that must be easy to understand and utilize and where utilized by members or Potential members must be at or below a grade four (4) reading level. The Contractor shall submit the Directory template to the Department for approval prior to finalizing the PCP Directory. The Contractor shall meet requirements of the Balanced Budget Act (BBA) for providing Provider Directory information to members in hardcopy, upon request. The Contractor will provide the hardcopy listings to members based on a defined geographic radius.

- The PCP Directory must include the following information regarding each PCP, at a minimum.
  - Contact information including name, all office site addresses, telephone number (including 24//7 access number) and email address;
  - Identification of the PCP's type of specialty (e.g. family practitioner, internist, etc.), subspecialty if applicable, and treatment age ranges;
  - Identification of group practice, if applicable;
  - PCP gender;
  - Geographic service area;
  - Hospital affiliations, including information about where the PCP has admitting privileges or admitting arrangements and delivery privileges (as appropriate),
  - Areas of board-certification, if applicable,
  - Language(s) spoken by PCP and/or office staff;
  - Panel status (open or closed);
  - Office hours and days of operation;
  - Special services offered to the deaf or hearing impaired (i.e., sign language, TDD/TTY, etc.);
  - Wheelchair accessibility status (e.g., parking, ramps, elevators, automatic doors, personal transfer assistance, etc.), and
  - Public transportation access (e g., public bus routes).

- The Contractor shall make every effort to provide current information in the PCP Directory. At a minimum, the Contractor shall update the PCP Directory weekly for its electronic version and monthly on paper versions.

3.21.2. PCCM/EPSDT Resource Directory

- The Contractor shall maintain a working knowledge of local public and private health-related resources in each community and parish of the state and whether or not they accept Medicaid eligibles.

- The Contractor shall have access to the Medicaid provider listing from the Fiscal Intermediary to be input in an automated resource directory database and shall update it as directed by the Department.

- This directory shall be enhanced by the Contractor to further refine the addition of information gathered by the Contractor and the sorting of this information. Access to specific criteria such as parish, specialty age, groups served or willingness to accept new Medicaid eligibles will aid in locating needed services.

3.22. Service Coordination for Special Needs Case Management

Service Coordination shall include but is not limited to:

- Assistance with referrals to specific services for all types of providers and follow-up on all types of referrals.
- Tracking referrals not the result of a screening but requested by phone.
- Assistance with requests for periodic and inter-periodic screens would be included with service coordination. This would include referrals to the appropriate PCCM/EPSDT provider as well as scheduling, if needed.
- Reports to be expanded to include referrals for all types of providers, results of follow-up, and tracking of request for periodic and inter-periodic screens.
- Additional informing activities such as distribution of brochures will be needed. The estimated volume of one (1) page brochure / flyers for development and distribution is two (2) mailings per year to approximately 4000 members.

3.23. Special Projects

3.23.1. Hospice

The Contractor will meet the guidelines and requirements regarding the Louisiana Medicaid Hospice Program. The Contractor will develop and implement procedures to perform the following duties related to the Medicaid Hospice Program for all enrollees in Louisiana Medicaid:

- **Initial 180 Days of Hospice Services**
  - The Contractor will receive, and review for completeness, appropriateness and timeliness, Hospice Recipient / Election/ Cancellation/Discharge Notice (NOE) and Certification of Terminal Illness (CTI) forms submitted during the initial 180 day period for hospice services. The Hospice Services Nurse will complete a thorough review of all hospice-related documentation. The Contractor will telephone the hospice provider to obtain additional information when needed. Tasks must be completed within five (5) working days of receipt of NOE/CTI forms

  - The Contractor will enter receipt date of completed NOE and CTI forms in the hospice data base and the effective date for hospice services in the MMIS system within five (5) working days from receipt of NOE/CTI forms.

  - The Contractor will enter data to include, but not limited to, member demographics, diagnosis codes, and hospice provider's name into the hospice data base within five (5) working days from receipt of NOE/CTI forms.

  - The Contractor will develop a hospice program patient tracking module that will ensure that all patients start of care and ongoing information is relayed to all services including input into the hospice database and the MMIS as necessary. Once on line, the Contractor will ensure that within five working days all member and hospice information will be entered into the hospice data base. The hospice module will be coded to ensure that all required information has been entered into the database prior to and upon determination of approval or denial.

  - The Contractor will send notice(s) advising hospice providers and nursing homes (if applicable) of the effective date or denial of hospice services within five (5) working days of receipt of NOE/CTI forms. The Contractor will establish a primary contact with each hospice provider and, where applicable, the nursing home. The hospice primary contact will assist the Contractor's Hospice Services Nurse in scheduling an initial Plan of Care Conference at the time of admission decision. The Contractor will develop an individual case record that includes initial admission information and routinely update. Letterhead correspondence will be provided to the hospice provider and nursing home (where applicable) of the election and effective date. The Contractor will meet the required timelines for updating the hospice database and MMIS with all required documentation.

  - The Contractor will implement and maintain internal tracking and process improvement processes and tools to ensure timeliness in written and verbal communications to hospice provider, nursing home, the Department's physicians, et.al. This will apply to, but not be limited to, admits, denials, ongoing eligibility, status change information and prior authorizations. The internal tracking process will ensure that timelines and documentation are met and adhered to for all hospice members.

- The Contractor shall maintain individual case files to include all documents, copies of outgoing correspondence and all contacts made and received on behalf of Medicaid recipients. These case files may be paper or electronic

- The Contractor will be given access to the Electronic Case Record (ECR) to scan NOE/CTI forms related to the initial 180 day period into the web-based system within seven (7) working days of final disposition. The Department maintains the ECR

- The Contractor shall prepare Summaries of Evidence for all hospice service denials, attend appeal hearings, testify, and present findings.

- **Prior Authorization of Hospice Services**
  - The Contractor will receive, and review for completeness and timeliness, updated CTI forms and supporting documentation from hospice providers requesting prior authorization for continued hospice services beyond the initial 180 day period. Documentation that will be received includes, but is not limited to, requests for services on hospice letterhead, updated plans of care, updated physician orders, progress notes for hospice services rendered during previous periods, and social evaluations.

  - Approval determinations and denial recommendations for requested hospice services will be determined by the Contractor within five (5) working days of receipt of completed Prior Authorization requests. The Contractor will contact the member's attending physician, hospice provider, authorized legal representative, hospital (if applicable), and/or nursing home (if applicable) to request additional medical documentation when submitted documentation is not adequate to make a determination. Additional documentation may include, but is not limited to, weight, lab reports, medication administration reports, nursing home orders/notes, hospital visits/admissions during nursing home stay, and Minimum Data Set (MDS).

  - On the day of prior authorization approval, the Contractor will submit a notice to the hospice provider indicating approved authorization of requested hospice services, as well update MMIS and Hospice Database to reflect the new election period.

- **Recommendation for Denial of Prior Authorization**
  - The Contractor shall prepare a summary report supporting Prior Authorization denial recommendations. Supporting documentation shall include, but is not limited to, verification of the information submitted in the Local Coverage Determination (LCD) Medical guidelines and documentation of the number of visits for hospice services received in the previous period (registered nurse, certified nurse assistant, social worker, chaplain, and aide).

  - Denial recommendations, summary reports, and pertinent supporting documentation shall be submitted to the Department for physician reconsideration. This documentation shall be submitted to the Department within two (2) business days of the denial recommendation.

  - Approval or denial recommendations from the Department physician shall be routed to the Contractor for entry into the MMIS system and Hospice Data Base. The Contractor shall send the appropriate notice to hospice providers and others indicating disposition of prior authorization request within two (2) business days of receipt of the determination (approval/denial) from the Department. Letterhead correspondence will be used and kept within the individual case record.

- **Processing Hospice Status Changes**
  - The Contractor will receive NOE forms from hospice providers reporting changes. The Contractor will update the Hospice Data Base and MMIS system within two (2) business days of receipt of reported changes. The Contractor will implement processes and procedures in consultation with the Department to ensure that all hospice records are accurately updated and maintained in a

secure environment (both electronic and hard copy) that meet all HIPAA privacy and security standards.

- **Registered Nurse Responsibilities**
  The Registered Nurse will perform the following duties related to the Medicaid Hospice Program:
  - Review hospice prior authorization requests and all supporting documentation to either approve or recommend denial.
  - Request additional information from the member or member's legal representative, member's attending physician, nursing home (if applicable), and/or hospital (if applicable) as needed to determine prior authorization approval or denial recommendation.
  - Prepare a summary report supporting Prior Authorization denial recommendations. Supporting documentation shall include, but is not limited to, verification of the information submitted in the Local Coverage Determination (LCD) Medical guidelines, documentation of the number of visits for hospice services received in the previous period (registered nurse, certified nurse assistant, social worker, chaplain, aide), and any other pertinent information used to determine the denial recommendation.
  - Act as liaison between the hospice providers and the Department as required.
  - Appear and/or testify at hospice related appeal hearings as requested by the Department

3.23.2. **Surveys (Provider and Member Satisfaction Surveys)**

- The Contractor will conduct provider and member satisfaction surveys on an annual basis.
- The Contractor will cooperate with the Department in developing surveys, as well as printing, mailing and implementing a process to sort and report results.
- A plan for these surveys including a timetable, and ensuing quality assurance should be submitted to the Department for approval no later than three (3) months after the initiation of the contract.
- The Contractor is to conduct a survey using a statistically valid stratified sample of all PCCM members regarding access to care, use of health services, and satisfaction with care and services.
- The Contractor must be a Consumer Assessment of Healthcare p and Systems (CAHPS) vendor or subcontract with a vendor to use the CAHPS 4.0 or later survey tool. The tool must be submitted for approval by the Department. Members are to be sampled every twelve (12) months.
- Member survey will be mailed, with telephone follow up which shall be a minimum of two (2) follow-ups on separate days.
- The Contractor will develop an application in which data can be summarized, sorted, and reports produced for analysis by the Department with recommendations for corrective action or policy changes when warranted.
- The Contractor is to develop and conduct a Department approved survey of the PCCM only enrolled providers annually. A statistically valid sample of these providers is required be used. The provider survey will be designed and created to emulate CAHPS methodologies with questions developed and submitted to the Department for approval.

3.23.3. **Trending**

- Preventive screenings, in both children and adults, assist in identifying medical conditions so that the conditions may be treated early. Early intervention can ensure

more positive health outcomes rather than those conditions elevating to a more acute or chronic level and more costly services needed. The Contractor will supply trending information reporting through the following:

- Quarterly submission of trending of children and adult preventive medical screenings.
- Identify by ages, geographical location, season, and other pertinent variables the target populations for visit reminders, education, and other outreach means to increase children and adult screening rates;

- The above deliverables must be submitted to the Department electronically according to a schedule to be set by the Department in collaboration with the Proposer within sixty (60) days of contract initiation; and
- The Contractor is responsible for any ad hoc reports as requested by the Department.

3.24. Telephonic Information Hotlines for Members and Providers

3.24.1. PCCM and EPSDT Call Center

- The Contractor shall establish a "user friendly" toll-free telephone line for providers, members, and their caregivers. The toll-free phone number shall be adequately staffed from 8:00 A.M. – 5:00 P.M. (Central Standard Time), Monday through Friday, excluding holidays (to be determined by mutual consent) to ensure no more than a two (2) minute wait time for callers. After a two (2) minute wait, calls must be rolled over to an automatic attendant for messaging. An automated phone system must be maintained for telephone calls received after hours with response to messages occurring the next business day.

- Important features of the telephone system will include but are not limited to:
  - Monitoring capabilities that allow supervisors to audit the manner in which a call is processed as well as the efficiency of the operator.
  - The Contractor will also maintain a TTY toll-free number for the hearing impaired as well as language interpretation services.
  - 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 EPSDT calls vs. PCCM calls,
    - 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 Contractor 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, medical providers) to a designated group of operators
  - A monitoring capability that allows instant determination of what mode an operator is in (available, on a call, completing after-work, etc.)
  - 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 Medicaid services available through PCCM and EPSDT programs.

- Within thirty (30) days of the start of the contract, the Contractor shall develop a training and evaluation module for call center staff to ensure adequate knowledge of PCCM and EPSDT benefits. The training module must be approved by the Department before implementation.

- The toll-free line shall allow members to:
  - Select a PCP or EPSDT provider;
  - Request a change of PCP;
  - Request information about accessing services;
  - Discuss problems with the program;

- Register complaints,
- Request screening services,
- Cancel screening appointments,
- Schedule or reschedule screening appointments;
- Schedule appointments for follow-up services;
- Request transportation and other assistance in accessing services; and
- Notify the Contractor of changes (i.e. new address, phone number, etc).

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

3.24.2. Specialty Care Resource Network and Helpline

- The Contractor shall develop and maintain a Specialty Care Resource Network database utilizing the existing Department lists of providers. The Specialty Care Resource Network shall include all provider types, including those who provide EPSDT services, who agree to be on the list and who receive referrals for all Medicaid eligibles (whether or not they are members of the PCCM).

- The Contractor shall provide the following information, at a minimum about each provider listed in the Resource Referral Network:
  - Contact information including name, address, telephone number, including after hours telephone number, email address and hospital affiliations;
  - Office hours and days of operation;
  - Identification of the provider's specialty, subspecialty and treatment age ranges;
  - For physicians, hospitals where physicians have admitting arrangements and delivery privileges;
  - Areas of board-certification, if applicable;
  - Information about whether the specialist is accepting new patients;
  - Language(s) spoken by specialist and/or office staff; and
  - Special services offered to the deaf or hearing impaired (i.e., sign language, TDD/TTY, etc.).

- The Contractor shall use the Specialty Care Resource Network to assist providers in referring any member for specialty care and follow-up treatment through a web-based system. The Specialty Care Resource Network will serve as a quick-reference system to aid providers and all Medicaid eligibles in easily identifying and locating appropriate specialty care providers who are accepting referrals. The Contractor and Providers shall use this Specialty Care Resource Network to assist all Medicaid eligibles not just PCCM Program members. The Contractor shall respond to any members' requests for assistance in finding appropriate health care services.

- The Contractor shall maintain a toll-free number to be used by providers and all Medicaid eligibles to obtain assistance in finding appropriate specialty care services and to access information regarding the Specialty Care Resource Network. It shall be a single, menu-driven line.

- The Contractor shall monitor the Specialty Care Resource Network, at a minimum of annually, to determine areas that have an insufficient number of providers to treat the number of referred members. In areas where such deficiencies exist, the Contractor shall identify and outreach to additional providers.

- Within the first thirty (30) days of the contract, The Contractor shall, with Department approval, develop a process to verify that all providers listed in the Specialty Care Resource Network are accepting new patients and track limitations regarding new patients (e.g., a provider who doesn't take patients who have certain special needs). Verification will take place at a minimum of quarterly.

- Any problems associated with a request for locating a provider and the inability to assist should be forwarded to the Department, via a method approved by the Department.

3.24.3. Immunization Record Retrieval Call Center

- The Contractor shall maintain, operate, and respond to requests to the Immunization Record Retrieval Call Center for Medicaid eligibles' immunization records from

eligibles' parents/guardians. Upon receiving a request for immunization records, the Contractor will:

- Mail a Department release form, along with the above letter, to be signed by the member (or the legal guardian if the member is a minor) and returned to the Contractor for maintenance of records.
- Search a database of paid Medicaid immunization claims;
- Search the Louisiana Immunization Network for Kids Statewide (LINKS) immunization registry for immunizations associated with the member request;
- Generate and mail a letter to the member's parent/guardian indicating:
- The immunizations found in claims history along with immunizations located in the LINKS registry; or
- The absence of immunization records in claims history and LINKS

3.24.4. Nurse Triage and Education Helpline

- Within the first thirty (30) days of the contract, the Contractor shall establish and maintain, for the Department, a separate Nurse Helpline for all PCCM members and all other non-PCCM Medicaid eligibles. This Nurse Helpline shall be available twenty-four (24) hours, seven (7) days per week.

- There shall be a sufficient number of Registered Nurses and Masters level counselors to accommodate calls from the population of 900,000 Medicaid eligibles with no more than a two (2) minute wait time for callers.

- Databases with nationally recognized standards of care will be used as protocol to triage calls, give assistance with health and medical information, and educate the Medicaid eligibles and members.

- Access to the Medicaid eligibles and providers file information is necessary in order to address specific eligibles and/or provider issues and such files will be available from the Fiscal Intermediary.

- Nurse Helpline must have language translation services as well as be able to accommodate the hearing impaired.

- A comprehensive reporting system must be in place to track calls, disposition of calls, sort calls by symptom, age, gender, PCP linkage, geographical location as well as answer times, holding time, hang ups, etc. Standard reporting as well as ad hoc reporting is expected.

- Nurse Helpline staff must place follow-up calls as appropriate and as directed by the Department.

- Nurse Helpline staff must assist members calling the Helpline in scheduling necessary PCP appointments by initiating a three way call with the member and the PCP Customer service representatives in the PCCM call center may assist with the scheduling of PCP appointment in lieu of or in addition to Nurse Helpline staff.

- Nurse Helpline will be an integral component of disease management and will work cooperatively with the Department or any Department Contractor in achieving positive results in the area of disease management.

- Nurse Helpline must have capability of identifying members triaged and referred to the Emergency Department or Urgent Care Facility (UCF) with forwarding of pertinent information to the members PCP to assist in achieving a true Medical Home. Information must be sent via fax or electronically secure email no later than the following business day.

- The Contractor must have the capability of issuing authorization numbers to submit to the Fiscal Intermediary for those ED claims for members referred to ED or Urgent Care Facility by the Nurse Helpline.

- Return on investment (ROI) shall be calculated quarterly and a state specific ROI calculation must be submitted to the state annually within ninety (90) days following

the state fiscal year end The methodology for determining the return on investment must be approved by the Department prior to use.

- The Nurse Helpline must be URAC accredited.

3.25. Information Technology

3.25.1. The Contractor shall be responsible for acquiring and maintaining necessary hardware, software, and network resources to support the requirements of the RFP. The Contractor shall also be responsible for the following:

- Adherence to all state and Federal regulations and guidelines, as well as industry standards and best practices, for information systems, data exchange, and any functions necessary to fulfill the requirements of the RFP. The Department requires that the system be stored in a secure and centralized database which adheres to HIPAA Compliance Regulations.

- All initial and recurring costs required for access to the Department systems, as well as Department access to the Contractor's systems. These costs include, but are not limited to, hardware, software, licensing, authority/permission to utilize any patents, annual maintenance, support, and connectivity with the Department and the Fiscal Intermediary;

- Identification of all systems which are considered to be proprietary.

- The capability to securely transfer or exchange data with the Department and the successor, in formats and within timelines approved by the Department, as described in the requirements of the RFP. The Contractor shall have the capability to interface with existing and future systems, such as the planned implementation of a new Fiscal Intermediary;

- Compliance with Section 508 of the Rehabilitation Act of 1973 with regards to any websites exposed to the public. All websites available for public access must be in compliance with Section 508 of the Rehabilitation Act of 1973 prior to publication Medicaid will maintain ownership rights to all internet registered domains for all websites exposed to the public;

- Provision of an outline and flow charts which describes how their solution will advance the MITA maturity level of the business processes described in the RFP.

- Develop, test and maintain Disaster Recovery and Business Continuity plans (DR/BCP) and procedures to allow them to continue to deliver essential business functions despite damage, loss or disruption of information technology due to the unexpected occurrence of a natural or man-made emergency or disaster;

    - The DR/BCP plans should include: Risk Assessment, Business Impact Analysis, Alignment to Business Strategy, Alignment to Business Continuity Strategy, and Testing and Updating Plans

    - The Contractor shall conduct in-service training for all staff designated for emergency operations/disaster recovery twice a year.

- Shall provide online documentation of system to be delivered:
    - upon implementation,
    - within 30 days of a major change ; or
    - as requested by the Department;

- Shall ensure system will be available 24 hours. Maintenance and down time shall be scheduled and approved by the Department. All unscheduled downtime must be reported to the Department immediately, with corrective action and workarounds; and

- Shall provide Department staff with real time access to the system and Contractor shall incur all of the costs related to this.

- Shall include a takeover plan or transition plan for any system transfer or other services listed within the RFP.

    - The Contractor shall develop and maintain 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 following stipulations:

        - 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 the Department;

        - In the event of contract termination, or as requested, the Contractor shall transfer all data and non-proprietary systems to the Department or new vendor within the agreed upon time frame. Any system developed or purchased with public funds that are determined the Department's Legal Office as non-proprietary must be turned over.

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

        - 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 Contractor and the Department.

3.25.2. CommunityCARE/KIDMED Website

- The Contractor will develop a website to be used by providers and members. This website will be interactive with programmatic information available, capability for providers and members to ask questions and receive answers, updates, messages and other information that will support the program objectives of all programs and health plans for which the Contractor has responsibility. Ability to communicate with providers and members via secure e-mail is acceptable. The website must provide Enrollee's the option to select or change their PCP, via an interactive web-based application. Criteria for the web page must be approved by the Department and follow all applicable regulations regarding confidentiality for Internet usage. Within thirty (30) days of the start of the contract, the website shall be functional and shall be updated two (2) times monthly at a minimum or as directed by the Department. The web site must have Spanish and Vietnamese versions.

- The website shall contain printable copies of all educational information developed for providers and members. The website will contain the most current PCP Directory. All updates/revisions to the website are to be reviewed and approved by the Department prior to posting.

3.25.3. Electronic Referral Authorization Support

- The Contractor will promote use of the Electronic Referral Authorization (e-RA) process with PCCM providers. The Contractor will have a working understanding of the (e-RA) system to answer general questions and refer more detailed questions to the Fiscal Intermediary provider relations staff. The Contractor will educate providers with no internet access on the advantages of the (e-RA) and electronically track provider contacts related to the (e-RA).

3.25.4. Provider Accessibility Monitoring

- The Contractor is to implement and maintain a provider accessibility application for PCCM. Data elements shall include but not be limited to the following:
    - Provider name
    - Phone
    - Parish of residence
    - Time of phone call
    - Date

- Detailed results such as no answer, machine, service, steps taken and numbers contacted
- Brief summary of the message
- Type of corrective action and date, and
- PCP's response

- The report will list "no answer" providers as well as reflect the number of times in a calendar year that "no answer" was the result of the monitoring.

3.25.5. Quality Reporting Application

- The Contractor shall develop and maintain a Quality Reporting application for PCCM and produce reports on the same as approved by the Department. To be included in this application is the referral information obtained from EPSDT claims data to be downloaded from the Fiscal Intermediary.

3.25.6. Questionnaire Survey for Providers and Eligibles

- The Contractor is to develop and maintain an electronic application to track and summarize findings from both members and provider questionnaires.

3.25.7. Member Complaints

- The Contractor is to design, develop, implement and maintain, subject to Department approval, an application to record, track, and summarize information for all member complaints regardless of the Medicaid health plan.

3.25.8. PCCM/EPSDT/ Management Application

- The Contractor shall accept eligibility, claims, and member data from the Department and/or store in an application in order to produce reports as required by the PCCM/EPSDT programs.

3.25.9. Provider Credentialing Application

- The Contractor will develop an application of all m credentialing information including, but not limited to, provider name, address, provider number, telephone number(s), licensure verification, and other pertinent items.

3.25.10. Email Blast Ability

- The Contractor 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

3.26. Contract Management

3.26.1. Staffing

- The administrative office of the Contractor for this project shall must be housed and located within the state of Louisiana, city of Baton Rouge, within ten (10) miles of the Department State Office Building located at 628 N. 4 St. Baton Rouge, LA 70802, with staff sufficiently out stationed to carry out functions of outreach, site certification and monitoring.

- The Department shall approve the hiring of all key professional personnel.

- Key professional personnel may not be removed or reassigned without approval of the Department.

- When vacancies of key staff occur, the Department shall be notified immediately and the vacancy shall be filled within thirty (30) days. Staff assignments shall be fully covered at all times. The Department shall consider changes of key personnel only after careful review.

- The Contractor shall include at a minimum the following key personnel:
  - Project Director should have at least six (6) years of experience in managing a similar project of equal or greater scope;

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

- Special Projects Director should have a minimum of five (5) years experience in public or private healthcare area. The Manager will supervise staff in the start up of the project by developing a project plan to ensure a successful and timely implementation and coordinate start-up activities between the Contractor and the Department. Ongoing responsibilities include healthcare research and quality development as related to Special Projects section of the RFP.

- Health Care Research and Quality Improvement Manager should be a registered nurse with a minimum of a B.S. degree in Nursing and should have five (5) years nursing experience with quality assurance programs and quality management including Monitoring Unit and working with regional nurses and other staff, in initiating and implementing a successful Quality Improvement System. Will supervise 2 quality improvement nurses.

- Quality Improvement Nurses: shall be R.N.s with a minimum of two (2) years nursing experience with quality assurance programs.

- R.N. Manager who is a registered nurse, and should have a minimum of five (5) years experience in public health, community health, pediatric preventive medicine or primary care. Will supervise a total of nine (9) field nurses and nine (9) field staff (one of each per region) for regional monitoring.

- Field Nurses: Must be Registered Nurses each must have a minimum of three (3) years experience in public health, community health, pediatric preventative medicine, utilization review, disease management, quality management, or primary care, and will have responsibilities for the PCCM program component as well as EPSDT.

- Field Staff: Must have a bachelor's degree, with three (3) - five (5) years experience in the healthcare field. Will work in tandem with field nurses to establish and maintain a qualified and satisfied quality provider network for both the PCCM program as well as EPSDT. Field staff will recruit and train providers into the CommunityCARE and KIDMED programs; provide assistance with enrollment; education about program requirements; and ongoing help to retain them in the provider network. This position will be the primary point of contact resource for all provider questions/concerns regarding the CommunityCARE and KIDMED programs.

- Medical Home Provider and Member Relations 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 Contractor 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 the RFP. Field and central office staff must be able to deal effectively with Medicaid eligibles.

- Outreach and Promotional Manager should have at least two (2) years of experience working in public relations, outreach, or promotional activities.

- All key professional staff must have a working knowledge of the Department, Medicaid, and the individual programs. The Contractor shall provide a detailed outline of the training plan and orientation package for staff.

- The Contractor's staff must possess sufficient Personal Computer expertise to provide for the reports and automation necessary to support the contract.

3.26.2. Complaints Regarding Proposer Staff

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

3.26.3. Contractor Staff National Background Check

- All temporary, permanent, subcontracted, part-time and full-time Contractor staff working on Louisiana Medicaid contracts must have a national criminal background

check prior to starting work on the contract. The results shall include all felony convictions and shall be submitted to the Department for review prior to the start of work on the contract.

- Any employee with a background unacceptable to the Department must be prohibited from working on Louisiana Medicaid contracts or immediately removed from the project by the Contractor. Examples of felony convictions that are unacceptable include but are not limited to those convictions that represent a potential risk to the security of data systems and/or Protected Health Information (PHI), potential for healthcare fraud, or pose a risk to the safety of Department employees.

- The national criminal background checks must also be performed every two years for all temporary, permanent, subcontracted, part-time and full-time Contractor staff working on Louisiana Medicaid contracts beginning with the 25th month following contract award. The Contractor will be responsible for all costs to conduct the criminal background checks.

- The Contractor shall provide the results of the background checks to the Department in a report upon completion. The format of the report shall be approved by the Department and shall include all copies of background checks as an appendix to the report.

- The Contractor must ensure that all entities or individuals, whether defined as "Key Personnel" 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)

- All temporary, permanent, subcontract, part-time and full-time Contractor 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 Contractor must notify the Department in writing on the same date the notice of a conviction or ineligibility is received.

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

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

3.26.4. CommunityCARE Contractor Action Plan

- The Contractor will develop and implement a CommunityCARE action plan which shall be submitted to the Department for review and approval. The CommunityCARE action plan shall be updated annually. The CommunityCARE action plan shall, at a minimum, address the following goals and related outcomes for increased provider participation and member access to services. Targeted provider and member outreach and education, as well as collaboration with the Department and other Department Contractors shall be included in the action plan. The first CommunityCARE action plan is due December 31, 2010.

- **Provider Participation Goals:**
  Goal 1: Assure that each parish has a minimum of two Medicaid participating PCP's each contract year (provided there is a Louisiana licensed PCP practicing in that parish);

  Goal 2: Increase the statewide number of participating PCCM PCP's (individual practitioner) by one (1) percent in each contract year, beginning with contract year one (May 1 – April 30, 2011. Each measurement year shall be compared to the number of PCPs (individual practitioner) in April of the prior year.

  Goal 3: Increase and maintain the statewide number of participating Medicaid providers (primary care and specialists) by a minimum of 15 in contract years one (1) and two (2); by a minimum of ten (10) in years three, four and five.

- **Member Access to Services Goals:**
  Goal 4: Increase the total number of Medicaid Enrolled children receiving a blood lead test at appropriate ages by three (3%) percent in each contract year Each measurement year to be compared to prior year; measurement will be the number from CMS 416 for federal fiscal year that ends in the contract year, compared to number from CMS 416 for previous federal fiscal year.

  Goal 5: Increase the total number of Medicaid enrollees under age of 21 receiving one (1) annual EPSDT preventive medical screen by one (1%) in contract year one, and two (2%) in each subsequent contract year Measurement will be the number from CMS 416 for federal fiscal year that ends in the contract year, compared to the number from CMS 416 for previous federal fiscal year

  Goal 6: Increase the number of Medicaid enrollees receiving a screening per the EPSDT periodicity schedule by one (1%) percent in contract year one, and two (2) percent in each subsequent contract year. Measurement will be the number from CMS 416 for federal fiscal year that ends in contract year, compared to number from CMS 416 for previous federal fiscal year.

  Goal 7: Increase the total number of Medicaid Enrolled adults (21 and over) receiving one (1) annual preventive office visit by one (1%) percent in contract year one, and three (3%) in each subsequent contract year. Each measurement year is to be compared to prior year.

  Nationally defined measures (i.e., HEDIS, CMS 416) will be used to assess member access to EPSDT screening services.

  The Department shall evaluate other member access to services utilizing administrative claims data. Measurements will be based upon date of service, taking into consideration the time needed for providers to submit claims for payment.

- CommunityCARE action plan goals shall be measured in a manner determined and agreed upon by the Department and the Contractor once the CommunityCARE action plan is approved. The Department will provide a copy of outcome measure reports and analyses to the Contractor.

- The annual CommunityCARE action plan shall identify the specific deliverables that will be accomplished to achieve the desired outcomes including targeted provider and member outreach and education. The CommunityCARE action plan shall be submitted to the Department June 30 of each contract year and approved by the Department prior to implementation by the Contractor. A CommunityCARE action plan status report shall be submitted to the Department no later than January 31 of each contract year. An annual CommunityCARE action plan final outcome report shall be submitted to the Department no later than June 30 following the end of each contract year. The final outcome report shall contain details exclusive to each target area, taking account of successes and identified barriers. The exact format of and elements to be incorporated in the final outcome report shall be determined and agreed upon annually by the Department and the Contractor once the CommunityCARE action plan is approved.

3.26.5. Reporting/Performance Measures

- Reports to be generated by the Contractor shall meet all state and federal reporting requirements. The needs of the Department, and other appropriate agencies for planning, monitoring and evaluation shall be taken into account in developing report formats and compiling data

- The Contractor may also be asked to produce additional ad-hoc reports in cooperation with other federal and/or state agencies upon request of the Department.

- All monthly reports shall be submitted by the Contractor within ten (10) calendar days of the last day of the month.

- Any weekly reports shall be submitted by the Wednesday following the reporting week.

- An annual report summarizing the status of the contract is to be received by the Department for approval within ninety (90) calendar days of the end of the first full contract year and each full contract year thereafter.

- Reports to be generated are listed below but are not limited to these and may include additional categories as required for state and federal reports or as described in the scope of work.

3.26.6. Member Reports

- Outreach Activities – number, location, results, detailed report on file
- Acceptors and decliners – number, location, age group
- Member contacts via Toll Free Telephone number – summary report by topic of call including member complaints
- Special Needs Case Management – tracking reports of all incoming call and disposition of calls from members and providers related to Special Needs Case Management
- Extended Home Health – tracking reports of all incoming calls and disposition of calls from members and providers related to Extended Home Health
- Immunization Record Retrieval Call Center – tracking reports of all incoming calls and outcome of these calls (e.g. number of calls, number of children's records requested, number of records mailed, etc.)
- Summarization of Linkages – new linkages, auto-assignments, choices, changes including reasons for change

3.26.7. Service Coordination Reports

- Transportation Services – number of requests, number approved, location, complaints
- Nurse Helpline Reports – Summary of number of calls, topic of calls, disposition and follow-up of calls.

3.26.8. Provider Reports

- **Program Support Site Visits**
  - Site Visits – number, location
  - Outcome – summary reports
  - PCCM Immunization Pay for Performance – number and location of sites outreach and assistance provided
  - Provider Recruitment – number, location, response

- **Monitoring**
  - Site Visits – number, location
  - Program Compliance – Summary Reports
  - Administrative procedures – Summary Reports
  - Outcome and Quality Assurance – Summary Reports
  - Corrective Action – Summary reports
  - Monitoring staff monthly and weekly schedules
  - Accessibility Reports – findings, actions, and types of responses of phone monitoring

- **Provider Listing and Linkage Report**
  - Current providers listed by parish and region, summary by region and state
  - Demographics – provider name, address, phone number
  - Medicaid information - Medicaid ID, provider type, provider specialty
  - Provider information – number of physicians, number of physician extenders, current linkages, potential capacity, panel restrictions
  - Map with regions delineated and number of providers per parish and mileage radius delineated. (GEO Mapping)
  - The above information should be provided for PCCM.

3.26.9. Annual Contract Status Report

Status of Contract Responsibilities – to be received by the Medicaid Director 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 for PCCM.

3.26.10. Hospice Reports

- Monthly reports and an annual summary report shall include the following:
  - Number of NOE and CTI forms received for each of the initial 90-day periods
  - Number of members who expired during each of the initial 90-day periods
  - Number of members who expired beyond the initial 180 days period
  - Diagnosis codes submitted on NOE/CTI forms during each of the initial 90-day periods
  - Number of provider NOE forms (to change hospice provider) received
  - Number of NOE forms (for revocations) received
  - Number of NOE forms (for discharges) received
  - Number of revocations with subsequent reelection
  - Number of discharges with subsequent reelection
  - Number or discharges/revocations secondary to hospitalization
  - Number of recipients receiving hospice in their homes
  - Number of recipients receiving hospice in a facility
  - Average length of time hospice services received (to include entire universe of hospice recipients and calculated to include those recipients that revoke and subsequently re-elect services)
  - Number of revocations secondary to hospitalization
  - Number of discharges secondary to hospitalization
  - Number of Prior Authorizations requests received
  - Number of approved Prior Authorization requests
  - Length of time (in days) to approve Prior Authorization requests
  - Length of time (in days) to review, authorize, or recommend denial of Prior Authorization requests (including days waiting for additional information from hospice provider)
  - Number of denial recommendations of Prior Authorization requests
  - Reasons for Prior Authorization request denial recommendations
  - Number of denial recommendations submitted for the Department's physician review
  - Number of Prior Authorization request denial recommendations that were overruled by the Department's physician.
  - Number of appeals for denials during initial 180 day period
  - Number of appeals for Prior Authorization denials
  - Outcomes of appeals
  - Number of Prior Authorizations requests that required request for additional documentation
  - Number of phone calls received from hospice providers, reasons for calls and responses provided
  - Number of calls received from members, members authorized representatives, reasons for calls and responses provided
  - Names of hospice providers, number of members receiving hospice services from each hospice provider, top 10 diagnosis codes for members receiving services from each hospice provider and length of time each member receives hospice services (including periods of revocation and subsequent re-election)

3.26.11. Meetings

Regular meetings will be scheduled by the Department with the Contractor. The Contractor 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) working days following the meeting. The Contractor will be responsible for the meeting summary preparation and distribution and obtaining approval from the Department.

3.26.12. **Contract Monitoring**

- The Medical Vendor Administration (Medicaid) establishes the policy and procedural requirements which PCCM providers must follow. The department will assign a Contract Monitor, over all liaison and point of contact between the Department the Contractor, with the PCCM Program Manager being primarily responsible for input regarding the PCCM components of the contract and the EPSDT Coordinator responsible for input regarding the EPSDT components of the contract.

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

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

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

- A detailed current description of PCCM services and provider requirements is contained in the PCCM Handbook and the 2007 Unisys PCCM Provider Training Packet.

3.26.13. **Liquidated Damages**

- In the event the Contractor fails to meet the performance standards specified within the contract, the liquidated damages defined below may be assessed If assessed, the liquidated damages will be used to reduce the Department's payments to the Contractor or if the liquidated damages exceed amounts due from the Department, the Contractor will be required to make cash payments for the amount in excess.

    - Late submission of required reports - $50.00 per working day, per report.
    - Failure to fill vacant contractually required key staff positions within 60 days - $500 per working day from 61st day of vacancy until filled with an employee approved by the Department.
    - Failure to maintain all files and perform all file updates according to the requirements in the contract - $200 per working day for each day after the agreed upon date.
    - Failure to comply with call center requirements as specified in the RFP or as agreed to by the Department - $200 per occurrence.
    - Inaccuracies in the Provider Enrollment Agreements approved by the Contractor - $100 per occurrence.
    - Failure to meet goals in the approved Action Plan member- $10,000 each year percentages not met.
    - Failure to comply with certification and monitoring deliverables- $200 per occurrence.

- The decision to impose liquidated damages may include consideration of some or all of the following factors:

- The duration of the violation;
- Whether the violation (or one that is substantially similar) has previously occurred;
- The Contractor's history of compliance;
- The severity of the violation and whether it imposes an immediate threat to the health or safety of the eligibles;
- The "good faith" exercised by the Contractor in attempting to stay in compliance.

3.26.14. Incentive Payments for CommunityCARE Contractor Action Plan Goals

- In the event the Contractor exceeds the performance standards specified within the contract, an incentive payment equal to the amounts defined below will be paid to the Contractor.

  - Success in exceeding two (2) of the seven (7) annual CommunityCARE action plan goals - $5,000 annually (SFY)

  - Success in exceeding three (3) of the seven (7) annual CommunityCARE action plan goals - $8,000 annually (SFY)

  - Success in exceeding four (4) of the seven (7) annual CommunityCARE action plan goals - $10,000 annually (SFY)

  - Success in exceeding five (5) of the seven (7) annual CommunityCARE action plan goals - $25,000 annually (SFY)

  - Success in exceeding six (6) of the seven (7) annual CommunityCARE action plan goals - $50,000 annually (SFY)

  - Success in exceeding seven (7) of the seven (7) annual CommunityCARE action plan goals - $70,000 annually (SFY)

3.26.15. Subcontracting

- The Contractor 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 Contractor shall not substitute any subcontractor without the prior written approval of the Department. For subcontractor(s), before commencing work, the Contractor will provide letters of agreement, contracts or other forms of commitment which demonstrates that all requirements pertaining to the Contractor will be satisfied by all subcontractors through the following:

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

3.26.16. 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.

- **Contractor's Insurance**

  The Contractor 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 Contractor 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 Contractor 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.

- **Compensation Insurance**
  Before any work is commenced, the Contractor shall obtain and maintain during the life of the contract, Workers' Compensation Insurance for all of the Contractor's employees employed to provide services under the contract. In case any work is sublet, the Contractor 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 Contractor. 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 Contractor 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.

- **Commercial General Liability Insurance**
  The Contractor shall maintain during the life of the contract such Commercial General Liability Insurance which shall protect Contractor, 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 Contractor 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.

- **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 Contractor, or by separate policies of insurance in the amounts as defined in any Special Conditions of the contract included therewith.

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

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

3.26.17. **Resources Available to Contractor**
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.

3.26.18. **Contact Personnel**
All work will be performed under the direct supervision of:

Contract Monitor
Medical Vendor Administration
Medicaid Reform Section
Bienville Building, 7th Floor
628 North 4th Street
Baton Rouge, LA 70802

3.26.19. **Term of Contract**

The term of this contract is for a period of 2 years with three (3) possible one (1) year extensions with the same terms and conditions. The continuation of this contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the contract.