PROGRAM ADMINISTRATOR
FOR
LOUISIANA MEDICAID
Primary Care Case Management

PROGRAM OPERATIONS
MEDICAL VENDOR ADMINISTRATION
DEPARTMENT OF HEALTH AND HOSPITALS

Release Date: July 15, 2009

Table of Contents

Glossary 4
1. General Information 6
1.1. Background 6
1.2. Purpose of Request for Proposal 6
1.3. Invitation to Propose 7
1.4. RFP Coordinator 7
1.5. Proposer Inquiries 8
1.6. Pre-Proposal Conference 8
1.7. Schedule of Events 8
1.8. RFP Addenda 9
2. Scope of Work 10
2.1. Scope of Work for Primary Care Case Management (PCCM) 10
2.1.1. Overview of Primary Care Case Management 10
2.1.2. How the Program Works 10
2.1.3. Exempted Services 12
2.1.4. Exempted Eligible Population 13
2.1.5. Primary Care Provider Enrollment 14
2.1.6. Number of PCCM Members by Parish 14
Table A: Number of PCCM Members by Parish As of April 2009 15
2.1.7. Project Overview and Statistics for current KIDMED Program (EPSDT) 17
Table B: Current EPSDT Screening Only (KIDMED) Members by Parish as of April 2009 19
2.2. Deliverables (Provider) 20
2.2.1. Recruiting 20
2.2.2. Certification and Monitoring 21
2.2.3. Provider Education 29
2.2.4. Annual Statewide Provider Training 31
2.2.5. Quality Management and Improvement 32
2.2.6. Provider Resources 34
2.3. Deliverables (Member) 35
2.3.1. Outreach 35
Table C: EPSDT Participation Report (CMS 416) 38
2.3.2. Member Complaints 39
2.3.3. Correspondence 39
2.3.4. Linkage- Enrollment Broker Responsibilities 40
2.3.5. EPSDT Screening Administration 42
2.3.6. EPSDT Healthcare Coordination 44
2.4. Deliverables (Special Projects) 53
2.4.1. Hospice 53
2.4.2. Surveys (Provider and Member Satisfaction Surveys) 53
2.4.3. Trending 54
2.4.4. Grant Research and Literature Review 54
2.5. Deliverables (Telephonic Information Hotlines for Members and Providers) 56
2.5.1. PCCM and EPSDT Call Center 56
2.5.2. Specialty Care Resource Network and Helpline 57
2.5.3. Immunization Record Retrieval Call Center 59
TABLE D: Immunization Record Retrieval Call Center Data 59
2.5.4. Nurse Triage and Education Helpline 59

2.6. Information Technology 61
2.6.2. Medical Home Web Site 62
2.6.3. Electronic Referral Authorization Support 63
2.6.4. Provider Accessibility Monitoring 63
2.6.5. Quality Reporting Application 63
2.6.6. Questionnaire Survey for Providers and Eligibles 64
2.6.7. Member Complaints 64
2.6.8. PCCM/EPSDT/ Management Application 64
2.6.9. Provider Credentialing Application 64
2.6.10. Email Blast Ability 64
2.7. Deliverables (Contract Management) 64
2.7.1. Staffing 64
2.7.2. Complaints Regarding Proposer Staff 66
2.7.3. Contractor Staff National Background Check 66
2.7.4. Reporting 67
2.7.5. Medical Home Contractor Action Plan 69
2.7.6. Provider Participation Goals: 69
2.7.7. Member Access to Services Goals: 70
2.7.8. Meetings 71
2.7.9. Contract Monitoring 71
2.7.10. Invoices 72
2.7.11. Liquidated Damages 72
2.7.12. Incentive Payments for Action Plan Goals 73
2.7.13. Subcontracting 73
2.7.14. Insurance Requirements 74
2.7.15. Resources Available to Contractor 75
2.7.16. Contact Personnel: 75
2.7.17. Term of Contract 76
2.7.18. Deliverables 76
3. Proposals 76
3.1. General Information 76
3.2. Procurement Library / Resources Available to Proposer 76
3.3. Proposal Submission 76
3.4. Proposal Cost 78
3.5. Ownership of Proposal 78
3.6. Certification Statement 78
3.7. Proposal Submission 79
3.8. Requested Proposal Outline 79
3.9. Content of Proposal Outline Listed Above 79
4. Other Information 85
5. Contractual Terms 86
Attachments: 87

Glossary

AAP - American Academy of Pediatrics
ACIP – Advisory Committee on Immunization Practices
ADA Claim Form – American Dental Association Claim Form
CAHPS – Consumer Assessment of Healthcare Providers and Systems
CLIA – Clinical Laboratory Improvement Amendments
CMS – Centers for Medicare and Medicaid Services
CommunityCARE – The State's Primary Care Case Management (PCCM) program which links Medicaid Eligibles to a Primary Care Provider (PCP) as their medical home
CPT – Current Procedural Terminology
DHH – Department of Health and Hospitals
ED – Emergency Department
EMC – Electronic Media Claims
e-MEVS – Electronic Medicaid Eligibility Verification System
Enrollment Broker – An entity that performs choice counseling, enrollment activities, or both
EPSDT – Early and Periodic Screening, Diagnostic and Treatment
e-RA – Electronic Referral Authorization
FI – Fiscal Intermediary
FFP – Federal Financial Participation
FQHC – Federally Qualified Health Center
HEDIS – Health Plan Employer Data and Information Set
HIPAA – Health Insurance Portability and Accountability Act
HMO – Health Maintenance Organization
IT – Information Technology
KIDMED – The Louisiana screening portion of the federally mandated Early and Periodic Screening, Diagnostic and Treatment program
LaCHIP – Louisiana Children's Health Insurance Program
LINKS – Louisiana Immunization Network for Kids Statewide
MCO – Managed Care Organization
MEM – Medicaid Eligibility Manual
Member(s) – Medicaid Eligibles who are participating in the State's Medical Home program
MEVS – Medicaid Eligibility Verification System
MMIS – Medicaid Management Information System
MOA – Memorandum of Agreement
MOU – Memorandum of Understanding
MVA – Medical Vendor Administration
NASHP – National Academy for State Health Policy
NCQA – National Committee for Quality Assurance
NOW – New Opportunities Waiver
NPI – National Provider Indicator
OBRA – Omnibus Budget Reconciliation Act
OCS – Office of Community Services
OFS – Office of Family Support
PACE – Program of All-Inclusive Care for the Elderly
PAHP – Prepaid Ambulatory Health Plan
PCCM – Primary Care Case Management
PCP – Primary Care Provider
PIHP – Prepaid Inpatient Health Plan

Proposer – Entity or company seeking contract to provide stated deliverables and services identified within RFP document
PSN – Provider Service Network
REVS – Recipient Eligibility Verification System
RFP – Request for Proposal
RHC – Rural Health Clinic
RN – Registered Nurse
ROI – Return on Investment
TDD/TTY – Telecommunication Device for the Deaf/Tele Typewriter
UCF – Urgent Care Facility
URAC – Utilization Review Accreditation Commission
WIC – Women, Infants & Children Supplemental Food Program

Choice counseling means activities such as answering questions and providing information (in an unbiased manner) on available MCO, PIHP, PAHP, or PCCM delivery system options, and advising on what factors to consider when choosing among them and in selecting a primary care provider.

Enrollment activities means activities such as distributing, collecting, and processing enrollment materials and taking enrollments by phone or in person;

Enrollment broker means an individual or entity that performs choice counseling or enrollment activities.

Enrollment services mean choice counseling, or enrollment activities, or both.

Must- Denotes a mandatory requirement

Shall-Denotes a mandatory requirement

Should- Denotes a preference but not a mandatory requirement

Will- Denotes a mandatory requirement

1. General Information

1.1. Background

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

1.1.2. DHH is comprised of the Medical Vendor Administration (Medicaid), the Office for Citizens with Developmental Disabilities, the Office of Mental Health, the Office for Addictive Disorders, Office of Aging and Adult Services, the Office of Public Health and the Bureau of Primary Care and Rural Health. Under the general supervision of the Secretary, these principal offices perform the primary functions and duties assigned to DHH.

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

1.1.4. Program Operations is the section within the DHH Medical Vendor Administration (Medicaid) which is responsible for the day to day operations of most Medicaid programs. Such programs include: Professional Services, RHC/FQHC, Hospitals, Home Health, EPSDT, PCCM, Dental, and Mental Health Rehabilitation.

1.2. Purpose of Request for Proposal

1.2.1. The Louisiana Department of Health and Hospitals (DHH), Medical Vendor Administration (Medicaid), Program Operations, issues this RFP to provide notice and information regarding procurement for continuation and expansion of a broad range of administrative services for a Medical Home Model in Medicaid. The goal of the Medical Home is coordination of care for Medicaid Eligibles resulting in positive impacts to the health care outcomes of these individuals.

1.2.2. PCCM

1.2.2.1. The Primary Care Case Management program (PCCM) currently operates statewide in all sixty-four (64) parishes. Medicaid Eligibles meeting the criteria for the PCCM Program are linked to a Primary Care Provider (PCP) for coordination of needed services. Currently, the Louisiana Medicaid PCCM program is called “CommunityCARE”.

1.2.2.2. The “KIDMED” Program is the screening portion of the federally mandated Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program. The KIDMED program is for Medicaid Eligibles between the ages of 0-21, and includes medical, vision, and hearing screenings as well as immunizations and routine lab work. The KIDMED program is aimed at

prevention and treatment of early childhood diseases that if unidentified could lead to more serious conditions.

1.2.2.3. It is the intent of the Department to blend the CommunityCARE and the KIDMED programs into a seamless and comprehensive Medical Home Model in the context of a PCCM program.

1.2.2.4. The purpose of this RFP is to contract with a company that has the capacity to provide Program Administration for all of the above functions.

1.2.3. Through this RFP, the Department intends to:

1.2.3.1. Provide specific information regarding the services to be provided.
1.2.3.2. Inform potential Proposers of the nature of the work to be performed as the Program Administrator for the PCCM Program.
1.2.3.3. Inform potential Proposers of the nature of the work to be undertaken as the Program Administrator for Enrollment Broker and Choice Counselor services for the PCCM.
1.2.3.4. Inform potential Proposers of the nature of the work to be undertaken as the Program Administrator relative to a comprehensive Medicaid Benefits Service Call Center for PCCM and all other Medicaid Eligibles.
1.2.3.5. Provide criteria used by the Department of Health and Hospitals in evaluation of the submitted proposals to interested Proposers.
1.2.3.6. Procure the services of a Contractor which will:
1.2.3.6.1. Ensure the PCCM program and screening portion of the EPSDT program operates as synchronously as possible in the context of the Medical Home Model.
1.2.3.6.2. Ensure care management and quality management is included in all aspects of the Medical Home Model.
1.2.3.6.3. Ensure coordination between awardee of this contract and all other departmental Contractors who have related goals.
1.2.3.6.4. Facilitate a smooth transition from one contract to the next.

1.3. Invitation to Propose

1.3.1. The DHH, Medical Vendor Administration (Medicaid), Program Operations Section is inviting qualified Proposers to submit proposals to provide Program Administrative services in accordance with the specifications and conditions set forth herein.

1.4. RFP Coordinator

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

Angela Mastainich
Medicaid Program Manager
Medical Vendor Administration
Program Operations
Department of Health and Hospitals
628 North 4th Street, 7th Floor
Baton Rouge, LA 70821

Phone: 225-342-4810
Fax: 225-376-4771
Email: Angela.Mastainich@la.gov

1.4.2. This RFP is available in PDF format at the following web link: http://www.dhh.louisiana.gov/publications.asp?ID=1&CID=25 .

1.5. Proposer Inquiries

1.5.1. The Department will consider written inquiries regarding the RFP or Scope of Services before the date specified in the Schedule of Events. To be considered, written inquiries and requests for clarification of the content of this RFP must be received at the above address or via the above fax number or email address by the date specified in the Schedule of Events. Any and all questions directed to the RFP coordinator will be deemed to require an official response and a copy of all questions and answers will be posted to the following web address http://www.dhh.louisiana.gov/publications.asp?ID=1&CID=25 by the date specified in the Schedule of Events.

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

1.6. Pre-Proposal Conference

1.6.1. A pre-proposal conference will be held on the date and time listed on the Schedule of Events. The conference will be located at 628 North 4th Street, (Bienville Building) Baton Rouge, LA 70821 conference room # 173. Prospective Proposers are highly encouraged to participate in the conference to obtain clarification of the requirements of the RFP and to receive answers to relevant questions.

1.6.2. Although impromptu questions will be permitted and spontaneous answers will be provided during the conference, the only official answer or position of the Department will be stated in writing in response to written questions. Therefore, Proposers should submit all questions in writing (even if an answer has already been given to an oral question). After the conference, questions will be researched and the official response will be posted on the Internet at the following link: http://www.dhh.louisiana.gov/publications.asp?ID=1&CID=25

1.7. Schedule of Events

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

Schedule of Events	Tentative Schedule
Public Notice of RFP	07/15/09
Pre-Proposal Conference	1:00pm CDT 7/23/09

Deadline for Receipt of Written Questions	4:00pm CDT 07/30/09
Response to Written Questions	08/14/09
Deadline for Receipt of Proposals	4:00pm CDT 09/03/09
Proposal Evaluation	09/04/09-09/18/09
Contract Award Announced	09/28/09
Contract Negotiations Begin –Takeover Period if Applicable	10/06/09
New Contract Begins	01/01/10

1.8. RFP Addenda

1.8.1. In the event it becomes necessary to revise any portion of the RFP for any reason, the Department shall post addenda, supplements, and/or amendments at the following web address: http://www.dhh.louisiana.gov/publications.asp?ID=1&CID=25

2. Scope of Work

2.1. Scope of Work for Primary Care Case Management (PCCM)

2.1.1. Overview of Primary Care Case Management

2.1.1.1. Currently, the Louisiana Medicaid PCCM program is called "CommunityCARE". The "KIDMED" Program is the screening portion 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.

2.1.1.2. Management components of the PCCM program include responsibilities related to Medical Home Provider, Medical Home Member, Special Projects, Information Technology, and Contract Management.

2.1.1.3. 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.

2.1.1.4. Other goals include:

2.1.1.4.1. Providing a "Medical Home" for Medicaid PCCM Members;
2.1.1.4.2. Promoting the educational and preventive aspects of health care to all Medicaid Eligibles;
2.1.1.4.3. Promoting the responsibility of the Member to use health care resources appropriately;
2.1.1.4.4. Supporting utilization of quality health care within the Member's community when appropriate; and
2.1.1.4.5. Informing all Medicaid Eligibles of the Medicaid services and providers available to them.

2.1.2. How the Program Works

2.1.2.1. Currently, the PCCM program operates according to the description outlined below. The Department will continue this basic process with enhancements or expansions to the current program included in the section on "Deliverables".

2.1.2.2. Potential Members have the opportunity to select a participating physician, clinic, Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Nurse Practitioner to be their Primary Care Provider (PCP) in their parish of residence, in a contiguous parish, or within thirty (30) minutes or thirty (30) miles of residence. The fact that each Member has a PCP allows continuity of care centered on a single provider who serves as their

Medical Home. Potential Members who do not select a PCP are auto-assigned to a participating provider in their parish of residence or a contiguous parish.

2.1.2.3. Auto-assignment is an electronic process performed by the Medicaid Fiscal Intermediary Contractor that is based on prior linkages, paid claims history, geographical location, and PCP restrictions. Members and potential Members have access to an established inquiry, complaint, and fair hearing process.

2.1.2.4. Those Medicaid Eligibles who are linked to a PCCM PCP, remain with their selected or assigned PCP for at least twelve (12) months if they do not request a change during the first ninety (90) days of any enrollment period. Members may request a change at any time if they were auto-assigned or for cause as identified in the PCCM Handbook. Members also have the opportunity to change PCP without cause during open enrollment period which is October 23 – December 23.

2.1.2.5. A full-time licensed Primary Care Physician may serve up to a maximum of 2500 Members plus 500 additional Members for each full-time certified physician assistant, certified nurse midwife, or licensed family nurse practitioner under the supervision of the PCP.

2.1.2.5.1. If it is determined that a Member has an existing relationship with a provider who is at the maximum, the provider may exceed the 2500 limit in order to maintain the existing Medical Home.

2.1.2.6. A Rural Health Clinic, staffed by a Nurse Practitioner with a collaborative physician or an independently enrolled Nurse Practitioner, may serve a maximum of 1000 Members per full time Nurse Practitioner.

2.1.2.7. Academic health teams comprised of one (1) staff physician, four (4) mid-level practitioners, and/or residents may serve up to a maximum of 2500 Members.

2.1.2.8. An enrolled PCP is eligible for a Per Member Per Month management fee in addition to normal fee-for-service reimbursement. (The most current policy will be available in the Procurement Library .)

2.1.2.9. As the primary care manager, the PCP bears total responsibility for managing all facets of the Members' health care.

2.1.2.9.1. This responsibility includes providing Member education, preventive care, maintenance and acute care, referral to specialists and other health care providers when necessary, and maintaining an integrated medical record of all care the Member receives.

2.1.2.9.2. PCPs must provide or arrange for the provision of routine preventive healthcare and age appropriate immunizations in accordance with EPSDT screening policies.

2.1.2.9.3. PCPs must also maintain hospital admitting privileges, or have formal arrangements for inpatient care, at a Medicaid participating hospital,

sufficient to meet the needs of all Members linked to him/her (not to exceed sixty (60) minutes travel time from the PCP's office to the hospital).

2.1.2.10. The PCP is responsible for exchanging medical information about the Member with emergency room physicians, specialist physicians, and other authorized providers. PCPs must provide for, or have arrangements to ensure, access to appropriate care for Members twenty-four (24) hours a day, seven (7) days a week. The PCP may authorize coverage in his/her absence or in emergencies in accordance with PCCM policy.

2.1.2.11. PCP's are responsible for providing ongoing primary care for all Members linked to their practice, including those under the care of other specialists. In these cases, PCP's are responsible for providing the basic primary care to Members and providing written referrals and/or referrals via the electronic referral system at the FI to specialists for additional medically necessary services.

2.1.2.12. In addition, every effort should be made by PCP's to provide a timely office appointment for emergency department follow-ups in accordance with the attending emergency room physician's direction.

2.1.2.12.1. PCP's or their designated back-ups are required to be available within one hour by telephone during regular office hours to answer Member medical questions and/or to respond to calls from providers in the emergency department.

2.1.2.13. Additional guidelines are detailed in the PCCM handbook. These measures should allow for most services to be provided in an office based situation and should decrease inappropriate utilization of the emergency department and ambulance transportation services, which are key goals of the program.

2.1.3. Exempted Services

2.1.3.1. Most health care services must be provided by or authorized by the PCP. The exceptions which do not require referrals are as follows:

2.1.3.1.1. Chiropractic service upon EPSDT referrals/authorizations, (ages 0 – 21)
2.1.3.1.2. Dental services (ages 0 – 21) (billed on the ADA claim form)
2.1.3.1.3. Dental services for pregnant women, ages 21 – 59 (billed on the ADA claim form)
2.1.3.1.4. Dentures for adults
2.1.3.1.5. The three (3)higher level (CPT 99283, 99284, 99285) emergency room visits and associated physician services [NOTE: The two (2) lower level Emergency room visits (CPT 99281, 99282) and associated physician services do not require prior authorization, but do require POST authorization. Refer to "Emergency Services" in the PCCM Handbook.]
2.1.3.1.6. Inpatient Care that has been pre-certified (this also applies to public hospitals even though they aren't required to obtain pre-certification

for inpatient stays): including hospital, physician, and ancillary services.

2.1.3.1.7. EPSDT Health Services – Rehabilitative type services such as occupational, physical and speech/language therapy delivered to EPSDT Members through schools or early intervention centers or the EarlySteps program.

2.1.3.1.8. Family planning services

2.1.3.1.9. Prenatal/Obstetrical services

2.1.3.1.10. Services provided through the Home and Community-Based Waiver programs

2.1.3.1.11. Targeted case management

2.1.3.1.12. Mental Health Rehabilitation (privately owned clinics)

2.1.3.1.13. Mental Health Clinics (State facilities)

2.1.3.1.14. Neonatology services while in the hospital

2.1.3.1.15. Ophthalmologist and Optometrist services

2.1.3.1.16. Pharmacy

2.1.3.1.17. Inpatient Psychiatric services (distinct part and freestanding psychiatric hospital)

2.1.3.1.18. Psychiatrists services

2.1.3.1.19. Transportation services

2.1.3.1.20. Hemodialysis

2.1.3.1.21. Hospice services

2.1.3.1.22. Specific outpatient laboratory/radiology services

2.1.3.1.23. Immunizations for children under age twenty-one (21) (Office of Public Health and their affiliated providers)

2.1.3.1.24. WIC services (Office of Public Health WIC Clinics)

2.1.3.1.25. Services provided by School Based Health Centers to Members age ten (10) and over

2.1.3.1.26. Tuberculosis clinic services (Office of Public Health)

2.1.3.1.27. STD clinic services (Office of Public Health)

2.1.3.1.28. Children's Special Health Services provided by Office of Public Health.

2.1.4. Exempted Eligible Population

2.1.4.1. All Medicaid Eligibles are required to enroll in the PCCM program, with the following exceptions:

2.1.4.1.1. Residents of Long Term Care nursing facilities or intermediate care facilities for the developmentally delayed (ICF/DD), such as state developmental centers and group homes.

2.1.4.1.2. Eligibles who are 65 years or older.

2.1.4.1.3. Eligibles with Medicare benefits, including dual Eligibles.

2.1.4.1.4. Foster children or children receiving adoption assistance.

2.1.4.1.5. Hospice Eligibles.

2.1.4.1.6. Office of Youth Development clientele (children in State custody).

2.1.4.1.7. Eligibles in the Medicaid physician/pharmacy Lock-In program (Members that are pharmacy-only Lock-In are not exempt).

2.1.4.1.8. Eligibles who have other primary insurance with physician benefits, including HMO's.

2.1.4.1.9. Eligibles who have an eligibility period of less than three (3) months.

2.1.4.1.10. Eligibles who have retroactive only eligibility (PCCM does not make retroactive linkages).
2.1.4.1.11. Native American Indians who reside in parish of Reservation (currently Jefferson Davis, St. Mary, LaSalle and Avoyelles parishes).
2.1.4.1.12. Certain medically high risk Members may warrant the direct care and exemptions are reviewed for approval on a case by case basis. Requests must be submitted in writing, along with supporting medical documentation of the Member's medical condition(s) to the Department. A preprinted request form is available on the PCCM web site, http://www.la-kidmed.com/
2.1.4.1.13. Medicaid Eligibles in the PACE program.
2.1.4.1.14. Eligibles in pregnant woman eligibility categories (type cases 13, 53, 104 and 127).
2.1.4.1.15. SSI Eligibles under the age of 19 (type case 78).
2.1.4.1.16. Eligibles under the age of 19 in the NOW and Children's Choice waiver programs (type cases 43, 70, 76, 77).
2.1.4.1.17. Eligibles under the age of 19 in the supports waiver and supports waiver SSI programs (type case 117 and 118).
2.1.4.1.18. Eligibles in the family planning waiver program (type case 115 and 116).
2.1.4.1.19. Eligibles in the LaCHIP Affordable Plan (type case 134).
2.1.4.1.20. Eligibles in a Provider Service Network (PSN).

2.1.4.2. Potential Members (Medicaid Eligibles who meet criteria to be enrolled in PCCM), including newborns, will be enrolled in PCCM within thirty (30) to sixty (60) days from their date of certification.

2.1.5. Primary Care Provider Enrollment

2.1.5.1. The following may participate as Primary Care Providers:

2.1.5.1.1. General Practitioners
2.1.5.1.2. Family Practitioners
2.1.5.1.3. Pediatricians
2.1.5.1.4. Internists (if practicing primary care in accordance with PCCM requirements)
2.1.5.1.5. Obstetricians/Gynecologists (if practicing primary care in accordance with PCCM requirements)
2.1.5.1.6. Academic Health Teams
2.1.5.1.7. Federally Qualified Health Centers (FQHCs)
2.1.5.1.8. Rural Health Centers (RHCs)
2.1.5.1.9. Nurse Practitioners (who meet specific additional requirements)

2.1.6. Number of PCCM Members by Parish

2.1.6.1. Approximately 700,000 Medicaid Eligibles participate in the PCCM. Each month about 13,000 new Medicaid Eligibles are sent a choice letter to select a PCP; approximately 80% of those are identified each month for auto-assignment because they failed to choose a PCP. In addition,

approximately 10,000 Members per month request PCP changes under the provisions noted in **Section 2.1.2.4**.

2.1.6.2. The following table denotes the current number of PCCM Members by parish for the month of April 2009:

Table A: Number of PCCM Members by Parish As of April 2009

Region 1			
Parish	**Ages 0-20**	**Ages 21-64**	**Total**
Jefferson (East)	20576	3803	24379
Jefferson (West)	32592	7296	39888
Orleans	44457	13123	57580
Plaquemines	2398	520	2918
St. Bernard	4510	1185	5695
Region 1 Totals	***104533***	***25927***	***130460***
Region 2			
Parish	**Ages 0-20**	**Ages 21-64**	**Total**
Ascension	10635	2075	12710
East Baton Rouge	58665	11455	70120
East Feliciana	2584	547	3131
Iberville	5261	1337	6598
Point Coupee	3113	761	3874
West Baton Rouge	2939	686	3625
West Feliciana	1042	177	1219
Region 2 Totals	***84239***	***17038***	***101277***
Region 3			
Parish	**Ages 0-20**	**Ages 21-64**	**Total**
Assumption	2816	779	3595
Lafourche	10172	2419	12591
St. Charles	5597	1106	6703
St. James	3127	760	3887
St. John	7430	1682	9112
St. Mary	8636	1681	10317
Terrebonne	14936	3384	18320
Region 3 Totals	***52714***	***11811***	***64525***
Region 4			
Parish	**Ages 0-20**	**Ages 21-64**	**Total**
Acadia	9515	1944	11459
Evangeline	5740	1735	7475
Iberia	12034	2503	14537

Lafayette	22624	3902	26526
St. Landry	16339	3702	20041
St. Martin	7382	1477	8859
Vermilion	7025	1537	8562
Region 4 Totals	***80659***	***16800***	***97459***

Region 5			
Parish	**Ages 0-20**	**Ages 21-64**	**Total**
Allen	3358	672	4030
Beauregard	4360	701	5061
Calcasieu	25156	3647	28803
Cameron	356	47	403
Jefferson Davis	4299	802	5101
Region 5 Totals	***37529***	***5869***	***43398***

Region 6			
Parish	**Ages 0-20**	**Ages 21-64**	**Total**
Avoyelles	6987	1714	8701
Catahoula	1685	352	2037
Concordia	3508	717	4225
Grant	2767	588	3355
LaSalle	1486	254	1740
Rapides	19251	3820	23071
Vernon	4963	927	5890
Winn	2226	488	2714
Region 6 Totals	***42873***	***8860***	***51733***

Region 7			
Parish	**Ages 0-20**	**Ages 21-64**	**Total**
Bienville	2163	515	2678
Bossier	10997	1950	12947
Caddo	36666	7549	44215
Claiborne	2112	524	2636
DeSoto	3416	676	4092
Natchitoches	5679	1090	6769
Red River	1465	275	1740
Sabine	2778	589	3367
Webster	5654	1220	6874
Region 7 Totals	***70930***	***14388***	***85318***

Region 8			
Parish	**Ages 0-20**	**Ages 21-64**	**Total**
Caldwell	1653	354	2007

East Carroll	2034	487	2521
Franklin	3787	747	4534
Jackson	1782	435	2217
Lincoln	5096	1091	6187
Madison	2585	551	3136
Morehouse	5468	1269	6737
Ouachita	23616	4638	28254
Richland	3701	703	4404
Tensas	1017	242	1259
Union	3182	600	3782
West Carroll	2049	395	2444
Region 8 Totals	***55970***	***11512***	***67482***
Region 9			
Parish	**Ages 0-20**	**Ages 21-64**	**Total**
Livingston	14084	2309	16393
St. Helena	1265	287	1552
St. Tammany	20861	3681	24542
Tangipahoa	20157	4387	24544
Washington	7415	1681	9096
Region 9 Totals	***63782***	***12345***	***76127***

2.1.7. Project Overview and Statistics for current KIDMED Program (EPSDT)

2.1.7.1. Currently, the EPSDT program operates according to the description outlined below. The Department will continue this basic process with enhancements or expansions to the current program identified in the section on “Deliverables”.

2.1.7.2. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services were established by Title XIX of the Social Security Act in 1967. Sections 1902 (a) (43) 1905 (1) (4) (B) and 1905 (r) of the Social Security Act, as amended, set forth the basic requirements for EPSDT services. Louisiana implemented EPSDT services in 1972. Significant changes were made to strengthen EPSDT benefits as a result of the passage of the Omnibus Budget Reconciliation Act of 1989 (OBRA-89) by Congress. These changes included:

2.1.7.2.1. Modifying the definition of screening services by including appropriate blood lead level testing and health education.

2.1.7.2.2. Requiring distinct periodicity schedules for screening, dental, vision and hearing services, and requiring medically necessary inter-periodic screening services.

2.1.7.2.3. Adding a new required service component of "other necessary health care, diagnostic, treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Medicaid plan".

2.1.7.2.4. Clarifying that nothing in the Medicaid law permits limiting EPSDT providers to those which can furnish all required EPSDT diagnostic or treatment services or as preventing qualified providers which can provide only one such service from program participation.

2.1.7.2.5. The OBRA-89 changes also included requirements relating to annual reporting and setting EPSDT participation goals for the States. In fiscal year 1989, the Proxy Measure of Louisiana's Participant Ratio was thirty-three (33) percent. During the period of the current EPSDT contract the Participant Ratio for 2007 – 2008 increased to sixty-six (66) percent. The participant ratio is the total number of eligibles receiving at least one (1) initial periodic screen divided by the total number of eligibles who should receive at least one initial or periodic screen. This ratio indicates the extent to which eligibles are receiving any initial and periodic screening services during the year.

2.1.7.2.6. KIDMED was adopted as the program name for EPSDT screening services in Louisiana effective March, 1991. The current contract for EPSDT services was initiated in March of 1998 in order to assist Louisiana in outreach and other management functions to ensure that the EPSDT participation goals continue to be met. A detailed current description of EPSDT screening services and provider requirements is contained in the KIDMED Provider Manual. (This manual is available in the Procurement Library .) Provider Updates are on the Louisiana Medicaid website at http://www.lamedicaid.com/provweb1/default.htm

2.1.7.2.7. As the state Medicaid agency, the Medical Vendor Administration establishes the policy and procedure requirements which govern the EPSDT program. The Medicaid Program coordinates services and maintains interagency agreements with the Title V agency (Maternal and Child Health Block grantee), which is the Office of Public Health and other state agencies, including the Department of Education, Office of Special Education and Head Start, as well as the Women, Infants and Children's Supplemental food Program (WIC). The Title V agency is required to inform WIC Eligible pregnant or postpartum women and parents of WIC Eligible children under age five (5) of the availability of EPSDT screening services. Head Start agencies also must explain EPSDT services to the parent(s) or guardian(s) of Medicaid enrolled children participating in Head Start and offer referrals for EPSDT services.

2.1.7.2.8. Current EPSDT Screening Only Members by Parish as of April 2009 are reflected below. The chart reflects members enrolled in the EPSDT Screening Program (KIDMED) and are not enrolled in the PCCM (CommunityCare).

Table B: Current EPSDT Screening Only (KIDMED) Members by Parish as of April 2009

EPSDT Screening Only (KIDMED) Members by Parish		
Parish Number	Parish Name	EPSDT Screening Only (KIDMED) Members
1	Acadia	724
2	Allen	245
3	Ascension	757
4	Assumption	192
5	Avoyelles	578
6	Beauregard	456
7	Bienville	320
8	Bossier	588
9	Caddo	4421
10	Calcasieu	2271
11	Caldwell	149
12	Cameron	31
13	Catahoula	123
14	Claiborne	280
15	Concordia	205
16	DeSoto	316
17	East Baton Rouge	4671
18	East Carroll	141
19	East Feliciana	171
20	Evangeline	504
21	Franklin	322
22	Grant	32
23	Iberia	1370
24	Iberville	779
25	Jackson	139
26	Jefferson (West)	2831
27	Jefferson Davis	506
28	Lafayette	1971
29	Lafourche	882
30	LaSalle	170
31	Lincoln	436
32	Livingston	851
33	Madison	240
34	Morehouse	513
35	Natchitoches	755
36	Orleans	2764
37	Ouachita	1642

38	Plaquemines	7
39	Point Coupee	316
40	Rapides	1712
41	Red River	242
42	Richland	433
43	Sabine	321
44	St. Bernard	84
45	St. Charles	552
46	St. Helena	107
47	St. James	242
48	St. John	675
49	St. Landry	1810
50	St. Martin	468
51	St. Mary	870
52	St. Tammany	2195
53	Tangipahoa	1774
54	Tensas	77
55	Terrebonne	2458
56	Union	256
57	Vermilion	490
58	Vernon	382
59	Washington	791
60	Webster	567
61	West Baton Rouge	35
62	West Carroll	119
63	West Feliciana	178
64	Winn	82
65	East Jefferson	2230
88	Counties in Mississippi	107
	Total	52926

2.2. Deliverables (Provider)

2.2.1. Recruiting

2.2.1.1. The Program Administrator shall collaborate with the Department's FI to proactively recruit PCP's 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 Program Administrator shall also recruit PCP's and specialists across State Lines in areas where residents generally seek medical care across state lines.

2.2.1.2. The Program Administrator 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.

2.2.1.3. During the term of the contract, the Program Administrator will perform 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.

2.2.1.4. The Program Administrator 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 Program Administrator will perform 4 targeted outreach projects each year, with the goal of increasing enrollment of specialists in La. Medicaid

2.2.1.5. To facilitate network development and recruitment, the Department will provide the Program Administrator with an electronic listing of Providers who currently participate in the Louisiana Medicaid Program. While the Program Administrator can use this list as a starting point, the Program Administrator 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 patient choice.

2.2.1.6. The Program Administrator 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 Program Administrator 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 Program Administrator.

2.2.1.7. The Program Administrator 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, mail outs, or other Program Administrator suggested activities approved by the Department

2.2.2. Certification and Monitoring

2.2.2.1. Provider Certification and Orientation

2.2.2.1.1. In conjunction with its recruiting efforts, the Program Administrator shall:

2.2.2.1.1.1. Provide an explanation of PCP responsibilities to each PCP;

2.2.2.1.1.2. Answer prospective Providers' questions;

2.2.2.1.1.3. 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 Relations Unit, and assist Providers to complete the Medicaid Provider Enrollment Application;

2.2.2.1.1.4. Assist Providers in completing the PCCM agreement;

2.2.2.1.1.5. Assist Providers in completing the enrollment process for electronic media claims (EMC) submission;

2.2.2.1.1.6. Assist Providers in enrolling in PCCM by obtaining signed PCP Program Agreements from Providers agreeing to serve as PCP's;

2.2.2.1.1.7. Track and report the reasons Providers give for electing not to join the Program;

2.2.2.1.1.8. Obtain and verify key PCP information outlined in the PCP application; and

2.2.2.1.1.9. Use Medicaid Provider identification numbers and National Provider Identifier (NPI).

2.2.2.1.2. The Program Administrator will provide for web-based provider enrollment, and is responsible for verifying validating 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, ensuring that the staff's days/hours do not overlap at other locations.

2.2.2.1.3. As part of the certification process, the Program Administrator 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.

2.2.2.1.4. In order to verify the provider's 24/7 coverage and hospital arrangements, the Program Administrator 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.

2.2.2.1.5. The Program Administrator 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 Program Administrator will contact the other provider to verify his/her agreement and understanding of his/her obligation as the admitting provider.

2.2.2.1.6. The Program Administrator shall 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.

2.2.2.1.7. 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.

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

2.2.2.1.9. Upon verification of enrollment criteria and a satisfactory site visit, the Program Administrator will electronically notify DHH of the new enrollment.

2.2.2.1.9.1. For EPSDT Provider Enrollment Agreements, the Program Administrator 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.

2.2.2.1.9.2. The Program Administrator will coordinate the approval and enrollment of EPSDT Screening Providers with DHH and Provider Enrollment staff.

2.2.2.1.9.3. Current enrollment procedures for EPSDT Screening Providers are available in the Procurement Library and detailed enrollment procedures including a Quality Assurance process for enrollments will be developed with the assistance of the Program Administrator at the time the contract is awarded.

2.2.2.1.10. Data compiled on site certification visits from field nurses is to be electronically transmitted to the Proposer'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.

2.2.2.2. Provider Certification and Orientation (EPSDT Screening Only)

2.2.2.2.1. In conjunction with its recruiting efforts, the Program Administrator shall:

2.2.2.2.1.1. Provide an explanation of the EPSDT Screening Program and the responsibilities to each EPSDT screening provider;

2.2.2.2.1.2. Answer prospective Provider's questions;

2.2.2.2.1.3. 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 Relations Unit, and assist Providers to complete the Medicaid Provider Enrollment Application;

2.2.2.2.1.4. The Program Administrator will provide for web-based EPSDT Screening Provider enrollment;

2.2.2.2.1.5. Assist Providers in completing the EPSDT Screening Provider agreement;

2.2.2.2.1.6. Assist Providers in completing the enrollment process for electronic media claims (EMC) submission;

2.2.2.2.1.7. 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:

a) Verification of equipment and supplies;
b) Verification of appropriate CLIA certificate;
c) Verification that provider's listed on enrollment documents as providing the EPSDT Screening services are enrolled in Medicaid.

2.2.2.2.1.8. Assist Providers in enrolling in EPSDT Screening Program by obtaining signed EPSDT Screening Program Agreements from Providers agreeing to serve as EPSDT Screening Providers;

2.2.2.2.1.9. Track and report the reasons Providers give for electing not to enroll in the EPSDT Screening Program;

2.2.2.2.1.10. Obtain and verify key EPSDT Screening Provider information outlined in the EPSDT Screening Provider application; and

2.2.2.2.1.11. Use Medicaid Provider identification numbers and National Provider Identifier (NPI).

2.2.2.2.1.12. The Program Administrator shall 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.

2.2.2.2.1.13. 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.

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

2.2.2.2.1.15. Data compiled on site certification visits from field nurses is to be electronically transmitted to the Proposer'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 Program Administrator will electronically notify DHH of the new enrollment.

2.2.2.2.1.16. The Program Administrator 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;

2.2.2.2.1.17. The Program Administrator will coordinate the approval and enrollment of EPSDT Screening Providers with DHH and Provider Enrollment staff;

2.2.2.2.1.18. 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 a annual basis;

2.2.2.2.1.19. The Contractor shall conduct on-site orientation for each newly enrolled EPSDT Screening Provider, addressing program requirements and standards for participation, no more than 10 days following approved enrollment.

2.2.2.2.1.20. The Program Administrator and the Contract Monitor shall develop a Quality Assurance process for enrollments at the time the contract is awarded.

2.2.2.3. Provider Monitoring Site Visits

2.2.2.3.1. The Program Administrator will perform both a compliance review and an outcomes audit via an annual site visit and records audit of all PCP and EPSDT only providers.

2.2.2.3.2. 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.

2.2.2.3.3. The Program Administrator 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 weren't, along with the reason the monitor didn't occur, and what corrective action is being taken.

2.2.2.3.4. 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.

2.2.2.3.5. During the monitoring site visit, the Program Administrator 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 Program Administrator and approved by the Department. The Program Administrator will notify DHH of any provider with an invalid or restricted license. The Department shall have inquiry capability to the credentialing application.

2.2.2.3.6. Provider documentation procedures and recording forms are reviewed by the Program Administrator. Periodicity scheduling, missed appointments, screening and referral procedures are also reviewed.

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

2.2.2.3.8. The records audit must be performed on a statistically valid stratified sample of Members using claims history data.

2.2.2.3.9. Provider deficiencies/non-compliance will be handled according to established procedures detailed in the Provider Deficiency Flow Charts. Flow charts may be found in the Procurement Library .

2.2.2.3.10. Program Administrator 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 Program Administrator 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.

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

2.2.2.3.12. 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 Program Administrator, if applicable.

2.2.2.3.13. The Program Administrator 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.

2.2.2.4. Electronic Monitoring System

2.2.2.4.1. The Program Administrator 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.

2.2.2.4.2. The Program Administrator 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.

2.2.2.4.3. The Department will continue to carry out limited random audits of providers as well as monitoring the Program Administrator.

2.2.2.4.4. Within thirty (30) days of the start of the contract, the Program Administrator 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.

2.2.2.5. Monitoring Accessibility of PCCM Providers

2.2.2.5.1. The Program Administrator 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.

2.2.2.5.2. The Program Administrator 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 Program Administrator 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 Member 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 Program Administrator, and the Program Administrator 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. Flow charts may be found in the Procurement Library .

2.2.2.5.3. Within thirty (30) days after the start of the contract, the Program Administrator must design and maintain an electronic application of provider phone monitoring with the data elements as outlined in the DHH monitoring documents included in the Procurement Library . The Program Administrator 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, with separate reports for PCCM and other health plans and shall be delivered ten (10) working days after the end of the month.

2.2.2.5.4. No more than one week prior to each six month recertification and each annual monitor the Program Administrator 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.

2.2.3. Provider Education

2.2.3.1. The Program Administrator 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, Program Administrator or the Department.

2.2.3.2. The Program Administrator 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 Program Administrator shall develop and release to Providers.

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

2.2.3.3.1. Member Enrollment Process - The Program Administrator must inform PCP's about the process for enrolling potential Members in the PCCM Program and with a PCP. The Program Administrator shall request Providers to encourage potential Members to voluntarily enroll in the Program to minimize the potential for disruption of existing PCP and Member relationships.

2.2.3.3.2. Member Verification Requirements – The Program Administrator 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.

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

2.2.3.3.4. EPSDT (Well Child) Screenings – The Program Administrator 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; anticipatory guidance and referral. Additionally, the Program Administrator 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 Program Administrator 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.

2.2.3.3.5. Referrals – The Program Administrator 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 Program Administrator shall educate Providers about steps to take when a Member schedules an appointment without a referral.

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

2.2.3.3.7. Provider On-line Utilization Reports – The Program Administrator shall educate Providers regarding use and analysis of the on-line Utilization Reports.

2.2.3.3.8. Eligible Education Topics – The Program Administrator shall educate Providers about how to handle Members who go to the wrong Provider office or who miss appointments frequently.

2.2.3.3.9. Miscellaneous Topics – The Program Administrator shall provide training and produce educational materials on general topics including cultural sensitivity, health care disparities and treating Members with special needs.

2.2.3.4. In addition to each of the specified Provider training topics, the Program Administrator 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.

2.2.3.5. The Program Administrator 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.

2.2.3.6. The Program Administrator shall provide ongoing communication with Providers that includes developing and distributing all needed Provider materials. The Program Administrator 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 Program Administrator 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 Program Administrator shall prepare and distribute additional Provider materials, upon request by the Department.

2.2.3.7. The Program Administrator shall develop and distribute quarterly Provider bulletins to communicate important updates and other helpful information. The Program Administrator shall make the Provider bulletin available on its website for Providers to access.

2.2.3.8. At a minimum, the bulletins must include the following information:

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

2.2.3.9. The Program Administrator shall distribute Provider bulletins or provider email update blasts, as requested by the Department.

2.2.3.10. The Program Administrator shall offer web-based educational modules 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 Program Administrator shall develop and implement a process for offering Continuing Education (CEs) for credit to the Medicaid medical professionals for Department approval. The Program Administrator shall track providers taking advantage of these educational opportunities and submit the related statistics in the monthly report.

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

2.2.4. Annual Statewide Provider Training

2.2.4.1. The Program Administrator will participate in annual Provider Training Workshops conducted by the Department Fiscal Intermediary. The Program Administrator 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 Program Administrator will be available to participate in any web-based or audio/video virtual workshops.

2.2.4.2. The Program Administrator 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 Program Administrator and through the PCCM programs. Training must either be coordinated by or approved by the Department.

2.2.5. Quality Management and Improvement

2.2.5.1. The Department is committed to continuously identifying opportunities for improvements and for developing and implementing strategies for quality improvement. The Program Administrator 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:

2.2.5.1.2. Quality Measurement

2.2.5.1.2.1. The Program Administrator 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 Program Administrator 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 Program Administrator shall measure quality indicators using HEDIS performance measures, but may use HEDIS-like measures if prior written approval is granted by the Department. The Program Administrator shall include in its RFP response a sample of the measures that will be used.

2.2.5.1.2.2. The Program Administrator will participate in the design, development and implementation of procedures for the study of clinical areas of concern as requested by the Department and will participate in collection and compilation of data necessary to conduct such focused quality of care studies (i.e., reviewing medical records, claims, administrative data, conducting special surveys, etc.

2.2.5.1.2.3. Focused quality of care studies must be conducted in accordance with current HEDIS measurements. 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 Program Administrator and the

Department will collaborate on the topic of studies to be completed. Over the course of the contract, five (5) focused studies must be completed with the timeline for the studies to be determined in collaboration with the Department.

2.2.5.1.2.4. Studies should be aimed at not only tracking rates and producing data, but at increasing rates and improving quality of service. After the baseline is established, the Department will set goals for increasing rates.

2.2.5.1.3. Quality Monitoring

2.2.2.1.3.1. Within the first thirty (30) days of the start of the contract, the Program Administrator 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:

a) Programmatic Quality

- The Program Administrator shall address aspects of quality of care that relate to policy level issues such as access to care, enrollment, retention, program costs, and PCP change reasons related to quality of care. Department staff and consultants will continue to carry out limited monitoring duties of providers as well as monitoring the Program Administrator.

- Within the first thirty (30) days of the start of the contract the Program Administrator 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 Program Administrator shall develop a process, subject to Departmental approval, which ensures that continuous quality improvement actions and follow-up are being taken based on monitoring findings.

b) Provider Quality Profile Education and Support

- The Program Administrator shall become familiar with the on-line Provider Quality Profiles and in conjunction with the Department determine the priority of nurse visits to counsel with providers who consistently are outside of state average ranges. HEDIS measures tracked on the Provider Quality Profiles include but are not limited to: diabetes, asthma, well child visits, and breast cancer screenings. Program

Administrator nurses must educate providers who are unfamiliar with HEDIS definitions and measures when such providers are identified.

- 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.

2.2.6. Provider Resources

2.2.6.1. Provider Support Site Visits

2.2.6.1.1. The Program Administrator shall visit each PCP provider site a minimum of quarterly, or upon request of the provider, to assist providers with questions/issues regarding the program.

2.2.6.1.2. In order to ensure proper credentialing of providers according to program standards as well as site certification for enrollment in the program, the Program Administrator 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 Program Administrator 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 Program Administrator and approved by the Department.

2.2.6.1.3. 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.

2.2.6.2. Program Support

2.2.6.2.1. The Program Administrator shall provide program support which includes the following:

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

2.2.6.2.1.2. 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.

2.2.6.3. Provider Incentives

2.2.6.3.1. 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. Detailed information on this initiative can be found at www.lamedicaid.com/provweb1/p4p.pdf and in the Procurement Library .

2.2.6.3.2. The Program Administrator will provide the following during onsite monitoring/certification visits as well as at any other appropriate contact with PCCM providers:

2.2.6.3.2.1. Outreach and overview of the Pay-for-Performance Initiative;
2.2.6.3.2.2. Requirements for participation in the initiative; and
2.2.6.3.2.3. Assistance as needed with the registration process for the initiative.

2.2.6.3.3. Currently there are approximately 286 out of 581 total PCCM providers registered and eligible for participation in the initiative. The Program Administrator will be responsible for recruitment of non-participating PCCM providers into the P4P initiative.

2.2.6.3.4. As other provider incentive initiatives are developed by the Department, the Program Administrator will be responsible for outreach and promotion of those initiatives.

2.3. Deliverables (Member)

2.3.1. Outreach

2.3.1.1. The Program Administrator 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 Program Administrator and the PCPs.

2.3.1.2. The Program Administrator Member outreach activities include but are not limited to:

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

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

2.3.1.2.3. Follow-up with Members under the age of twenty-one (21) who does not make an appointment with a PCP within 120 days of enrolling in the PCCM Program.

2.3.1.2.4. Outreach to Participants 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.

2.3.1.2.5. 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.

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

2.3.1.2.7. 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 Program Administrator outreach staff or nurses, and working with parish health departments, schools and other community agencies to reach families.

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

2.3.1.2.9. 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.

2.3.1.2.10. Implementation of strategies to outreach to Members on the importance of adult preventive visits.

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

2.3.1.2.12. Development and implementation, with Department approval, of a Member Educational Newsletter to be mailed semi-annually to PCCM Members.

2.3.1.2.13. 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.

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

2.3.1.2.15. The Program Administrator 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.

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

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

2.3.1.2.18. Education about the importance of planned pregnancies, prenatal care for pregnant women and other available services such as Take Charge and WIC.

2.3.1.2.19. The Program Administrator 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 Program Administrator 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.

2.3.1.2.20. 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.

2.3.1.2.21. Member outreach will be a shared responsibility between the Program Administrator and the PCP.

2.3.1.2.22. The Program Administrator will work in coordination with the Department to develop and host an annual Medical Home Week for PCCM Members and providers to showcase successful outcomes of the Medical Home.

2.3.1.2.23. Sixty-five (65) percent of the Eligible Medicaid population received EPSDT medical screening services in the twelve (12) month federal reporting period ending September 30, 2007. Screening data on unduplicated counts from the EPSDT Participation Report (CMS 416) for this period are given below:

Table C: EPSDT Participation Report (CMS 416)

AGE GROUP	<1	1-2	3-5	6-9	10-14	15-18	19-20	TOTAL
#Eligibles Due Screen	48,707	92,253	110,574	68,344	91,097	58,615	14,089	483,679
# Receiving at Least One Screen	43,931	67,868	67,649	45,907	53,172	34,101	3746	316,374
Member Ratio	90%	73%	61%	67%	58%	58%	26%	65%
Expected # of Screens	153,500	165,520	110,574	68,344	91,097	58,615	14,089	661,739
# Screenings Received	162,559	178,734	90,004	54,419	66,105	43,207	4374	599,402
Screening Ratio	105%	107%	81%	79%	72%	73%	31%	90%

2.3.1.3. 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.

2.3.1.4. The Program Administrator 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.

2.3.1.5. The Program Administrator shall maintain and modify, as requested by DHH, 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.

2.3.1.6. The Program Administrator shall have access to the MMIS Recipient file. This will assist the Program Administrator in identifying new Medicaid Eligibles for outreach activities. Release of Member information shall be in conformity with Section 2090.18 of the State Medicaid Manual on

"Contracts with Outside Parties to Confirm Eligibility" and 42 CFR 437, Subpart 5, Section 1902 (a) (7) of the Social Security Act and the Health Information Portability and Accountability Act.

2.3.1.7. Memorandums of Understanding

2.3.1.7.1. The Program Administrator 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 Program Administrator 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 EarlySteps, 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.

2.3.2. Member Complaints

2.3.2.1. Within thirty (30) days of the start of the contract, the Program Administrator will design, develop and implement, subject to DHH approval, a process to handle Member complaints in a manner compliant with Federal, State and program policies and guidelines.

2.3.3. Correspondence

2.3.3.1. Every month approximately 10,000 new potential Members are identified statewide. The Program Administrator is responsible for establishing and maintaining procedures for coordinating with the FI all facets of preparation, printing, and mailing of choice notices to Members. (Sample notice in Procurement Library) This choice notice currently is a two-sided legal length page which contains all of the required information. This mailing also includes a parish specific provider listing from which Members in each parish choose their PCP. 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 (Sample booklet in Procurement Library).

2.3.3.2. Notices shall be produced and mailed at the direction of the Department. Additionally, the Program Administrator 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.

2.3.3.3. The Program Administrator is also responsible for preparation, printing, and mailing of Open Enrollment notices to all Members once annually. The Program Administrator 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.

2.3.4. Linkage- Enrollment Broker Responsibilities

2.3.4.1. Linking PCCM Members with a Medical Home

2.3.4.1.1. The Program Administrator shall be responsible for the input of data to update computer files on all PCCM Members as well as PCCM providers. The Program Administrator'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 Program Administrator 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 Program Administrator shall ensure adherence to the DHH 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 any or all of their EPSDT screening services.

2.3.4.2. Linking Non- PCCM Members with a Screening Provider

2.3.4.2.1. The Program Administrator 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 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 periodically. A minimum of one (1) follow-up contact shall be made by the Program Administrator on all declinations to encourage the Eligible to reconsider and participate.

The follow-up contact shall be made by telephone if possible. The Program Administrator is responsible for such follow-up.

2.3.4.2.2. The Program Administrator 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 Program Administrator 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. A current list of providers is available in the Procurement Library .

2.3.4.2.3. An EPSDT form letter further explaining and confirming the selection of EPSDT screening provider(s) is sent by the Program Administrator 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.

2.3.4.3. Exemption Requests

2.3.4.3.1. The Program Administrator 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 Program Administrator will prepare and mail correspondence to the Member and/or requesting provider advising of the approval. If the request is denied, the Program Administrator will forward the information to the Department for final resolution.

2.3.4.4. Disenrollment of Member by PCP

2.3.4.4.1. 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. Change request reasons must be tracked and reported to the Department monthly. The Program Administrator 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 Program Administrator 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.

2.3.4.5. Conditions that enrollment brokers must meet.

2.3.4.5.1. 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:

2.3.4.5.1.1. 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-

a) Is an MCO, PIHP, PAHP, PCCM or other health care provider in the State;
b) Is owned or controlled by an MCO, PIHP, PAHP, PCCM, or other health care provider in the State; or
c) Owns or controls an MCO, PIHP, PAHP, PCCM, or other health care provider in the State.

2.3.4.5.1.2. 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, or consultant of the broker or subcontractor or has any contract with them:

a) 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;
b) Has been excluded from participation under title XVIII or XIX of the Social Security Act of 1965 as amended (hereinafter "the Act";
c) Has been debarred by any Federal agency; or
d) Has been, or is now, subject to civil money penalties under the Act.

2.3.4.5.1.3. 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]

2.3.5. EPSDT Screening Administration

2.3.5.1. The Program Administrator, 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.

2.3.5.2. Maintaining Updated Files of Members and Providers

2.3.5.2.1. 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.

2.3.5.2.2. There were approximately 668,000 Members under age twenty-one (21) as of February 2008. The number of Medicaid Eligible children has increased as new groups of Eligibles have been added as result of federal mandates and state options. The number of children Eligibles has increased steadily since OBRA-89. Additional statistical information on Members is available in the Procurement Library .

2.3.5.3. Scheduling Initial Screenings

2.3.5.3.1. The Program Administrator 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 within the required time limits.

2.3.5.3.2. 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:

2.3.5.3.2.1. (Screening only) Newborns-within two (2) weeks of birth
2.3.5.3.2.2. Children one (1) month to three (3) years of age within forty-five (45) days of the date of contact (medical screening only)
2.3.5.3.2.3. Children three (3) to six (6) years of age-within sixty (60) days of the date of contact
2.3.5.3.2.4. Children six (6) to twenty-one (21) 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 Program Administrator regarding screening services.

2.3.5.4. Scheduling Periodic Screenings

2.3.5.4.1. The Program Administrator 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.

2.3.5.4.2. The Program Administrator 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 Program Administrator to do this on Members one (1) year or older. Standard procedure shall be developed for the screening provider to notify promptly the Program Administrator of the appointment date or

vice versa. These procedures shall include utilizing the universal EPSDT screening claim form for this purpose, or HIPAA mandated forms when appropriate.

2.3.5.4.3. The Program Administrator 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 Program Administrator shall establish a reasonable timetable for reminder letters, to be sent out and telephone contacts or other identified efforts to successfully contact Members for whom appointments have been scheduled.

2.3.5.4.4. Providers may also perform inter-periodic screenings as provided in the EPSDT Manual. Refer to EPSDT (KIDMED) Provider Manual in the Procurement Library for explanation of inter-periodic screenings.

2.3.5.5. Rescheduling Missed Screening Appointments

2.3.5.5.1. The Program Administrator shall have access to and input data to the electronic screening appointment rescheduling tickler in order to reschedule missed screening appointments, unless the provider wishes to handle rescheduling.

2.3.5.5.2. The Program Administrator shall reschedule any missed medical, vision, hearing and dental screening appointment and document same.

2.3.5.6. Tracking Screening

2.3.5.6.1. The Program Administrator 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 Program Administrator 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 Program Administrator 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.

2.3.5.6.2. The Program Administrator 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.

2.3.6. EPSDT Healthcare Coordination

2.3.6.1. Service Coordination

2.3.6.1.1. The Program Administrator 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:

2.3.6.2. Scheduling Diagnosis and Treatment

2.3.6.2.1. The Program Administrator 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.

2.3.6.2.2. The Program Administrator 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 Program Administrator shall be capable of giving appropriate referral resource information to 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 Program Administrator shall be responsible for providing information regarding these referrals as requested by the PCP. Information regarding referrals shall ensure freedom of choice of providers.

2.3.6.2.3. The Program Administrator shall maintain knowledge of community based health care resources available to assist Members in obtaining needed services not covered by Medicaid.

2.3.6.2.4. 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.

2.3.6.2.5. The Program Administrator 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.

2.3.6.2.6. The Program Administrator 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 Program Administrator.

2.3.6.3. Tracking Diagnosis and Treatment

2.3.6.3.1. The Program Administrator 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.

2.3.6.4. Rescheduling Missed Diagnosis or Treatment Visits

2.3.6.4.1. The Program Administrator will be responsible for rescheduling missed appointments for medically necessary services resulting from screenings as part of the service coordination responsibilities.

2.3.6.4.2. The Program Administrator shall reschedule missed diagnosis treatments and document same.

2.3.6.4.3. The Program Administrator 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.

2.3.6.4.4. The Program Administrator will not be responsible for scheduling appointments for ongoing medical treatment on Members after treatment is initiated.

2.3.6.5. Transportation Management

2.3.6.5.1. The Program Administrator 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:

2.3.6.5.1.1. Receiving telephone requests for transportation for Medicaid Eligibles under age twenty-one (21) years;

2.3.6.5.1.2. Screening transportation request, determining if free resources are available and determining eligibility for Medicaid covered transportation according to Medicaid policy;

2.3.6.5.1.3. Assist with transportation for Medicaid Eligibles under twenty-one (21) years old via contact with dispatch contractor;

2.3.6.5.1.4. Documenting transportation requests according to Department procedures; and

2.3.6.5.1.5. Referring scheduling problems and complaints between Medicaid Eligibles and transportation providers to Department transportation program staff.

2.3.6.6. Coordination with Other Service Programs

2.3.6.6.1. 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.

2.3.6.6.2. The Program Administrator 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.

2.3.6.7. Member Education

2.3.6.7.1. 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).

2.3.6.7.2. The Program Administrator 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.

2.3.6.7.3. The Program Administrator shall develop education aimed at helping Members become empowered to be:

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

2.3.6.7.4. The Program Administrator 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 sixth (6th) grade reading level.

2.3.6.7.5. The Program Administrator 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.

2.3.6.7.6. The Program Administrator shall coordinate its Member education activities with the Department, so that initiatives are not duplicative and so that similar information conveyed by multiple entities is outreach efforts, including printing and mailing materials.

2.3.6.8. Member Educational/ Program Material

2.3.6.8.1. The Program Administrator will produce, and distribute educational/program materials with Departmental approval to inform the Members of the requirements of the PCCM program. 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.

2.3.6.8.2. Educational materials will be reviewed by Department staff and the Program Administrator, at a minimum, on an annual basis and updated as needed to maintain compliance with requirements of the Balanced Budget act of 1997, and changes in Federal and State Medicaid program policies.

2.3.6.8.3. Member educational/program material includes but is not limited to:

2.3.6.8.3.1. Newsletters issued at least quarterly that provide updates about issues such as covered services and the access to Providers;

2.3.6.8.3.2. Literature about health or wellness promotion and healthy lifestyle practices;

2.3.6.8.3.3. Educational materials about preventive adult services and the management of common chronic diseases;

2.3.6.8.4. The Program Administrator 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 (sample brochure in Procurement Library).The Program Administrator 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. This brochure will be distributed to BHSF, OFS, and OCS parish offices as well as Medicaid providers at their request;

2.3.6.8.5. Within the first thirty (30) days from the start of the contract, the Program Administrator shall produce and distribute a multi-page

PCCM/EPSDT Member booklet to all new PCCM Members each month following the choice notice (sample booklet in Procurement Library). 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;

2.3.6.8.6. The Program Administrator shall develop and distribute, to providers, videos and posters approved by the Department;

2.3.6.8.7. The Program Administrator 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 must be revised to comply with program requirements. The brochures must be approved by the Department. Alternate designs will be considered by the Department. (Examples of current brochure designs are included in the Procurement Library);

2.3.6.8.8. A separate brochure designed for non-PCCM Members who are under twenty-one (21) years of age; and

2.3.6.8.9. Informational materials, such as pamphlets, brochures, posters and videos, informing families of children under the age of twenty-one (21) of the importance of well-child care and EPSDT services. The brochures shall be in English, Vietnamese, and Spanish with a separate brochure designed for non-PCCM Members who are under twenty-one (21) years of age. In addition, information must be available for the visually impaired.

2.3.6.8.10. These materials shall include at a minimum:

2.3.6.8.10.1. How and when to utilize services;
2.3.6.8.10.2. The importance of scheduling and keeping appointments, including the periodicity schedule;
2.3.6.8.10.3. The importance of EPSDT (well child) screening and follow up as recommended;
2.3.6.8.10.4. 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;
2.3.6.8.10.5. The process for receiving assistance to make appointments for EPSDT, if needed;
2.3.6.8.10.6. Educational materials addressing issues specific to Members with special needs, for example, materials about HIV/AIDS and developmental disabilities;
2.3.6.8.10.7. 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;
2.3.6.8.10.8. Promotional materials such as brochures and posters; and

2.3.6.8.10.9. Program bulletins that notify Members of significant policy or Program changes at least thirty (30) days prior to the effective date of the change.

2.3.6.8.11. 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

2.3.6.8.12. The Program Administrator shall review and approve, 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 Program Administrator shall notify provider of decision regarding their marketing materials.

2.3.6.8.13. A copy of the Medicaid Eligibility Manual's (MEM) policy related to informing applicants and Members of EPSDT screening services is in the Procurement Library .

2.3.6.9. Member Quality and Chronic Care Management Program Materials

2.3.6.9.1. The Program Administrator 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.

2.3.6.9.2. The Program Administrator 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. These educational materials should be available in non-English languages as determined by the Department.

2.3.6.9.3. The Program Administrator shall produce pocket guides on specific disease/quality areas as directed by the Department for use by provider staff.

2.3.6.9.4. The Program Administrator shall produce and distribute Member educational letters with enclosed pamphlets once during the first six (6) months of the contract and once every six (6) months thereafter for the duration of the contract.

2.3.6.9.5. The Program Administrator shall produce promotional items, such as magnets, on specific disease/quality topics as directed by the Department.

2.3.6.9.6. The Program Administrator shall produce reminder postcards/mail outs for providers to use with Members. These postcards/mail outs will contain educational tips as well as space for appointment information.

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

2.3.6.9.8. The Program Administrator shall establish an agreement with the Chronic Care Management Program Contractor. The agreement shall specify that the two entities must:

2.3.6.9.8.1. Work in partnership to reduce inappropriate ER utilization;
2.3.6.9.8.2. Work to encourage appropriate service utilization associated with asthma, diabetes or other chronic diseases as identified by the department;
2.3.6.9.8.3. Work to share Member and Provider information in a timely manner, as appropriate; and
2.3.6.9.8.4. Establish methods and procedures for the efficient and timely exchange of Member and Provider information, as appropriate.

2.3.6.9.9. 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.

2.3.6.10. Member Resources

2.3.6.10.1. PCP Directory

2.3.6.10.1.1. The Program Administrator 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 six (6) reading level. The Program Administrator shall submit the Directory template to the Department for approval prior to finalizing the PCP Directory. The Program Administrator shall meet requirements of the Balanced Budget Act (BBA) for providing Provider Directory information to Members in hardcopy, upon request.

2.3.6.10.1.2. The PCP Directory must include the following information regarding each PCP, at a minimum:

a) Contact information including name, all office site addresses, telephone number (including 24//7 access number) and email address;
b) Identification of the PCP's type of specialty (e.g. family practitioner, internist, etc.), subspecialty if applicable, and treatment age ranges;
c) Identification of group practice, if applicable;

d) PCP gender;
e) Geographic service area;
f) Hospital affiliations, including information about where the PCP has admitting privileges or admitting arrangements and delivery privileges (as appropriate);
g) Areas of board-certification, if applicable;
h) Language(s) spoken by PCP and/or office staff;
i) Panel status (open or closed);
j) Office hours and days of operation;
k) Special services offered to the deaf or hearing impaired (i.e., sign language, TDD/TTY, etc.);
l) Wheelchair accessibility status (e.g., parking, ramps, elevators, automatic doors, personal transfer assistance, etc.), and
m) Public transportation access (e.g., public bus routes).

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

2.3.6.11. PCCM/EPSDT Resource Directory

2.3.6.11.1. The Program Administrator 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.

2.3.6.11.2. The Program Administrator 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.

2.3.6.11.3. This directory shall be enhanced by the Program Administrator to further refine the addition of information gathered by the Program Administrator 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.

2.3.6.12. Service Coordination for Special Needs Case Management

2.3.6.12.1. Service Coordination shall include but is not limited to:

2.3.6.12.1.1. Assistance with referrals to specific services for all types of providers and follow-up on all types of referrals.
2.3.6.12.1.2. Tracking referrals not the result of a screening but requested by phone.
2.3.6.12.1.3. 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.

2.3.6.12.1.4. 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.

2.3.6.12.1.5. Additional informing activities such as distribution of brochures will be needed.

2.4. Deliverables (Special Projects)

2.4.1. Hospice

2.4.1.1. The Program Administrator will provide a nurse to perform the following duties:

2.4.1.1.1. Review all incoming requests for continued hospice services after an initial 180 day period.

2.4.1.1.2. Contact the hospice provider, patient, patient's authorized legal representative and nursing home (if applicable) to justify the denial or approval for continued services if submitted documentation is not sufficient to make a determination.

2.4.1.1.3. Prepare a report comparing medical documentation submitted from previous periods. This should include the verification of the information submitted in the Local Coverage Determination (LCD) Medical guidelines. Document the number of visits from each service (registered/licensed practical nurse, certified nurse assistant, social worker, chaplain, aide).

2.4.1.1.4. Request documentation from nursing homes (if applicable) and compare the information. This documentation should include weight, lab reports, medication reports to justify if there have been increases in pain medication, nursing home orders/notes, hospital visits and Minimum data set (MDS).

2.4.1.1.5. Review for numerous revocations and discharges to determine if the patient is seeking aggressive treatment.

2.4.1.1.6. Attend all requests for an appeal when prior authorization is denied. He/she will testify at these hearings and present his/her findings in the form of a summary, from documentation submitted by the hospice provider and nursing home (if applicable). This summary shall document the nursing home information compared to the hospice provider submitted information.

2.4.2. Surveys (Provider and Member Satisfaction Surveys)

2.4.2.1. The Program Administrator will conduct Provider and Member Satisfaction surveys.

2.4.2.2. The Program Administrator will cooperate with DHH in developing surveys, as well as printing, mailing and implementing a process to sort and report results.

2.4.2.3. 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.

2.4.2.4. The Program Administrator is to conduct a survey using a statistically valid sample of the PCCM Members regarding access to care, use of health services, and satisfaction with care and services.

2.4.2.5. The Program Administrator must be a Consumer Assessment of Healthcare Providers and Systems (CAHPS) vendor and is to use the CAHPS 4.0 or later survey tool and must be submitted for approval by the Department. Members are to be sampled every twelve (12) months.

2.4.2.6. Member survey will be mailed, with telephone follow up.

2.4.2.7. The Program Administrator 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.

2.4.2.8. The Program Administrator is to develop and conduct a Department approved survey of the PCCM only enrolled providers annually. A statistically valid sample of these providers must be used.

2.4.3. Trending

2.4.3.1. 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 Program Administrator will supply trending information reporting through the following:

2.4.3.1.1. Quarterly submission of trending of children and adult preventive medical screenings;

2.4.3.1.2. 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;

2.4.3.1.3. 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

2.4.3.1.4. The Program Administrator is responsible for any ad hoc reports as requested by the Department.

2.4.4. Grant Research and Literature Review

2.4.4.1. Monthly Report

2.4.4.1.1. The Program Administrator will submit a monthly report outlining result of grant research and literature review related to the Medical Home which will include the following:

2.4.4.1.1.1. Listing and description of any grants available;
2.4.4.1.1.2. Recommendations on grants for which an application should be considered;
2.4.4.1.1.3. Recommendations for direction of content;
2.4.4.1.1.4. Support for and/or writing of grant proposals;
2.4.4.1.1.5. Articles of Interest from professional journals, websites and other resources;
2.4.4.1.1.6. Summary of articles of interest;
2.4.4.1.1.7. Recommendations as to any action that could be considered by the Department; and
2.4.4.1.1.8. Contact with reviewed sources as directed by the Department.

2.4.4.2. Analysis of National Guidelines and Recommendations

2.4.4.2.1. National health guidelines are updated routinely and must be reviewed by the Department to ensure ongoing compliance with mandated guidelines. The Department also welcomes opportunities for program and policy revisions for improving compliance with national standards for provisions of healthcare.

2.4.4.2.2. The Program Administrator will submit a semi-annual summary report of research related to changes in guidelines for the following:

2.4.4.2.2.1. Includes HEDIS, Preventive Medicine Guidelines, Primary Care Guidelines, etc. Sources could include AAP, ACIP, CAHPS, NCQA, NASHP and other nationally recognized organizations.
2.4.4.2.2.2. Recommendations as to any action that could be considered by the Department

2.4.4.3. Provider Manual

2.4.4.3.1. The Program Administrator shall utilize the Department's PCCM Manual produced by the Fiscal Intermediary and at least annually or as often as needed, research and recommend changes to the Department regarding applicable national and state health guidelines that would affect program policy.
2.4.4.3.2. The Program Administrator shall provide recommendations based on certification and monitoring visits as well as data from PCCM reporting and observations, that would as well enhance program policy.
2.4.4.3.3. The Program Administrator will assist with revisions to the EPSDT Screening provider manual.
2.4.4.3.4. The Program Administrator will provide the Department with research and recommendations regarding applicable national and state health guidelines that would affect program policy.
2.4.4.3.5. The Program Administrator will provide recommendations based on program support site visits and monitoring visits, as well as data from

EPSDT reporting and observations, that would enhance program policy.

2.5. Deliverables (Telephonic Information Hotlines for Members and Providers)

2.5.1. PCCM and EPSDT Call Center

2.5.1.1. The Program Administrator shall establish a "user friendly" toll-free in-state telephone line for Providers, Members, and their caregivers. The toll-free telephone number shall be adequately staffed from 8:00 a.m. – 5:00 p.m. 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. Currently, approximately 35,000 – 40,000 PCCM and EDSDT program incoming and outgoing calls are handled per month. An automated phone system must be maintained for telephone calls received after hours with response to messages occurring the next business day.

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

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

2.5.1.2.2. The Program Administrator will also maintain a TTY toll-free number for the hearing impaired as well as language interpretation services.

2.5.1.2.3. Reporting capabilities that provide such information as:

2.5.1.2.3.1. Length of time per call;

2.5.1.2.3.2. Number of calls waiting (or in queue);

2.5.1.2.3.3. Number of calls abandoned;

2.5.1.2.3.4. Number of calls per hour;

2.5.1.2.3.5. Number of calls waiting more than two (2) minutes;

2.5.1.2.3.6. Individual operator workload;

2.5.1.2.3.7. Reason for the call;

2.5.1.2.3.8. Number of EPSDT calls vs. PCCM calls,

2.5.1.2.3.9. Number of calls received after hours;

2.5.1.2.3.10. 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 Program Administrator shall have health informational messages on the line; and

2.5.1.2.3.11. Amount of call center downtime.

2.5.1.2.4. Automatic routing of call to the next available operator

2.5.1.2.5. Capability of routing calls from specific sources (e.g., Members, medical providers) to a designated group of operators

2.5.1.2.6. A monitoring capability that allows instant determination of what mode an operator is in (available, on a call, completing after-work, etc.)

2.5.1.2.7. Capability for all calls to be answered promptly (within three (3) rings coming out of hold message) during normal business hours.

2.5.1.2.8. The toll-free number shall be staffed by trained personnel who have a working knowledge of Medicaid services available through PCCM and EPSDT programs.

2.5.1.3. Within thirty (30) days of the start of the contract, the Program Administrator 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.

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

2.5.1.4.1. Select a PCP or EPSDT provider;

2.5.1.4.2. Request a change of PCP;

2.5.1.4.3. Request information about accessing services;

2.5.1.4.4. Discuss problems with the program;

2.5.1.4.5. Register complaints;

2.5.1.4.6. Request screening services;

2.5.1.4.7. Cancel screening appointments;

2.5.1.4.8. Schedule or reschedule screening appointments;

2.5.1.4.9. Schedule appointments for follow-up services;

2.5.1.4.10. Request transportation and other assistance in accessing services; and

2.5.1.4.11. Notify the Program Administrator of changes (i.e. new address, phone number, etc).

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

2.5.2. Specialty Care Resource Network and Helpline

2.5.2.1. The Program Administrator 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).

2.5.2.2. The Program Administrator shall provide the following information, at a minimum about each Provider listed in the Resource Referral Network:

2.5.2.2.1. Contact information including name, address, telephone number, including after hours telephone number, email address and hospital affiliations;

2.5.2.2.2. Office hours and days of operation;

2.5.2.2.3. Identification of the Provider's specialty, subspecialty and treatment age ranges;

2.5.2.2.4. For physicians, hospitals where physicians have admitting arrangements and delivery privileges;

2.5.2.2.5. Areas of board-certification, if applicable;

2.5.2.2.6. Information about whether the specialist is accepting new patients;

2.5.2.2.7. Language(s) spoken by specialist and/or office staff; and

2.5.2.2.8. Special services offered to the deaf or hearing impaired (i.e., sign language, TDD/TTY, etc.).

2.5.2.3. The Program Administrator 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 Program Administrator and Providers shall use this Specialty Care Resource Network to assist all Medicaid Eligibles not just PCCM Program Members. The Program Administrator shall respond to any Members' requests for assistance in finding appropriate health care services.

2.5.2.4. The Program Administrator 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.

2.5.2.5. The Program Administrator 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 Program Administrator shall identify and outreach to additional Providers.

2.5.2.6. Within the first thirty (30) days of the contract, The Program Administrator shall, with DHH 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.

2.5.2.7. 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.

2.5.3. Immunization Record Retrieval Call Center

2.5.3.1. The Program Administrator 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 Program Administrator will:

2.5.3.1.1. Mail a DHH 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 Program Administrator for maintenance of records.
2.5.3.1.2. Search a database of paid Medicaid immunization claims;
2.5.3.1.3. Search the Louisiana Immunization Network for Kids Statewide (LINKS) immunization registry for immunizations associated with the Member request;
2.5.3.1.4. Generate and mail a letter to the Member's parent/guardian indicating:
2.5.3.1.4.1. The immunizations found in claims history along with immunizations located in the LINKS registry; or
2.5.3.1.4.2. The absence of immunization records in claims history and LINKS
2.5.3.1.5. The following table includes a recent month's Immunization Record Retrieval Call Center data:

TABLE D: Immunization Record Retrieval Call Center Data

Calls requesting immunization records	137
Total number of children the requests were for	202
Number of letters mailed	103
LINKS information not found	15
Claims information not found	16
Claims or LINKS information not found	0

2.5.4. Nurse Triage and Education Helpline

2.5.4.1. Within the first thirty (30) days of the contract, the Program Administrator 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.

2.5.4.2. 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.

2.5.4.3. 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.

2.5.4.4. 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.

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

2.5.4.6. 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.

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

2.5.4.8. 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.

2.5.4.9. Nurse Helpline staff must assist in Member surveys, studies, and educational outreach as directed by DHH.

2.5.4.10. Nurse Helpline must have capability of flagging Member files for identification of disease states as directed by the Department.

2.5.4.11. The Nurse Helpline must have the capability of using pre-scripted information for targeted Members as directed by the Department for disease management/educational purposes.

2.5.4.12. 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.

2.5.4.13. 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.

2.5.4.14. Nurse Helpline must work cooperatively and interface with “Operation Redirect” Contractors. This is Louisiana Medicaid’s CMS grant initiative for ER Diversion.

2.5.4.15. The Program Administrator 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. In SFY 2007, approximately 3,900 triage referrals were made to ED’s or UCF’s.

2.5.4.16. The Program Administrator will develop and issue, at the Department’s direction, educational material for providers and/or Members for management of chronic diseases or other health initiatives such as preventive screenings, immunizations, or ED utilization with anticipation of about four (4) mailings per year to approximately 100,000 Members each or eight (8) mailings per year to about 50,000 Members each.

2.5.4.17. 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.

2.5.4.18. The Nurse Helpline must be URAC accredited.

2.6. Information Technology

2.6.1. The Program Administrator:

2.6.1.1. Shall be responsible for acquiring and maintaining necessary hardware, software, and network resources to support the requirements of this RFP;

2.6.1.2. Shall adhere 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 this RFP;

2.6.1.3. Shall be responsible for all initial and recurring costs required for access to DHH systems, as well as DHH access to the Program Administrator'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 DHH and the Fiscal Intermediary;

2.6.1.4. Shall identify in their proposal all systems which are considered to be proprietary.

2.6.1.5. Shall have the capability to securely transfer or exchange data with DHH in formats within timelines approved by Medicaid and as described in the requirements of this RFP. The Program Administrator shall have the capability to interface with existing and future systems, such as the planned implementation of a new Fiscal Intermediary;

2.6.1.6. Shall comply 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;

2.6.1.7. Shall provide an outline and flow charts which describes how their solution will advance the MITA maturity level of the business processes described in this RFP. The current maturity and business capability level of the processes are provided in the Procurement Library to the Proposer as a guide for potential areas of improvement;

2.6.1.8. Shall 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;

2.6.1.8.1. DR/BCP are to be submitted to DHH for approval at time of proposal. The plans should include: Risk Assessment, Business Impact Analysis, Alignment to Business Strategy, Alignment to Business Continuity Strategy, and Testing and Updating Plans

2.6.1.9. Shall provide online documentation of system to be delivered upon implementation, within 30 days of a major change and as requested by DHH;

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

2.6.1.11. Shall provide DHH staff with real time access to the system and Program Administrator shall incur all of the costs related to this.

2.6.1.12. Shall include a takeover plan or transition plan for any system transfer or other services listed within this RFP at the time of Proposal.

2.6.1.13. 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:

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

2.6.1.13.2. 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;

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

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

2.6.2. Medical Home Web Site

2.6.2.1. The Program Administrator 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 Program Administrator has responsibility. 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.

2.6.2.2. The web site shall contain both a provider and a Member newsletter (each to be updated quarterly) with current news/information that would be of interest and relevant to providers and Members.

2.6.2.3. The website will contain a list of PCCM PCP's listed by parish, along with their locations, practice restrictions, and non-English languages spoken. This list should be updated monthly. The Program Administrator will establish a process for identifying and capturing the various non-English languages spoken in the providers' offices.

2.6.2.4. All updates/revisions to the website (including the newsletters) are to be reviewed and approved by the Department prior to posting.

2.6.3. Electronic Referral Authorization Support

2.6.3.1. The Program Administrator will promote use of the Electronic Referral Authorization (e-RA) process with PCCM providers. The Program Administrator 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 Program Administrator will educate providers with no internet access on the advantages of the (e-RA) and track provider contacts related to the (e-RA).

2.6.4. Provider Accessibility Monitoring

2.6.4.1. The Program Administrator is to implement and maintain a provider accessibility application for PCCM. Data elements shall include but not be limited to the following:

2.6.4.1.1. Provider name
2.6.4.1.2. Phone
2.6.4.1.3. Parish of residence
2.6.4.1.4. Time of phone call
2.6.4.1.5. Date
2.6.4.1.6. Detailed results such as no answer, machine, service, steps taken and numbers contacted
2.6.4.1.7. Brief summary of the message
2.6.4.1.8. Type of corrective action and date, and
2.6.4.1.9. PCP's response

2.6.4.2. 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.

2.6.5. Quality Reporting Application

2.6.5.1. The Program Administrator 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.

2.6.6. Questionnaire Survey for Providers and Eligibles

2.6.6.1. The Program Administrator is to develop and maintain an electronic application to track and summarize findings from both Members and Provider questionnaires.

2.6.7. Member Complaints

2.6.7.1. The Program Administrator 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.

2.6.8. PCCM/EPSDT/ Management Application

2.6.8.1. The Program Administrator 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.

2.6.9. Provider Credentialing Application

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

2.6.10. Email Blast Ability

2.6.10.1. The Program Administrator 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.

2.7. Deliverables (Contract Management)

2.7.1. Staffing

2.7.1.1. The administrative office of the Program Administrator for this project shall must be housed and located within the state of Louisiana, city of Baton Rouge, within ten (10) miles of the DHH 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.

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

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

2.7.1.4. 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.

2.7.1.5. The Program Administrator shall include at a minimum the following key personnel:

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

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

2.7.1.5.3. 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 Program Administrator and the Department. Ongoing responsibilities include healthcare research and quality development as related to Special Projects section of RFP.

2.7.1.5.4. 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.

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

2.7.1.5.6. 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 eighteen (18) field nurses (two Nurses per region) for regional monitoring.

2.7.1.5.7. 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.

2.7.1.5.8. 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 Program Administrator to meet the objectives and to carry out the scope or work delineated in this proposal. In addition, sufficient telephone operators and staff must be provided to support the level of effort

required to comply with this RFP. Field and central office staff must be able to deal effectively with Medicaid Eligibles.

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

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

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

2.7.2. Complaints Regarding Proposer Staff

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

2.7.3. Contractor Staff National Background Check

2.7.3.1. 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.

2.7.3.1.1. 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.

2.7.3.1.2. 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.

2.7.3.1.3. 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.

2.7.3.1.4. 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).

2.7.3.2. 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 DHH in writing on the same date the notice of a conviction or ineligibility is received.

2.7.3.2.1. 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.

2.7.3.1. 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.

2.7.4. Reporting

2.7.4.1. Reports to be generated by the Program Administrator 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.

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

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

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

2.7.4.5. 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.

2.7.4.6. 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.

2.7.3.6.1. Member Reports

2.7.3.6.1.1. Outreach Activities – number, location, results, detailed report on file
2.7.3.6.1.2. Acceptors and decliners – number, location, age group
2.7.3.6.1.3. Member contacts via Toll Free Telephone number – summary report by topic of call including Member complaints
2.7.3.6.1.4. Special Needs Case Management – tracking reports of all incoming call and disposition of calls from Members and Providers related to Special Needs Case Management
2.7.3.6.1.5. Extended Home Health – tracking reports of all incoming calls and disposition of calls from Members and Providers related to Extended Home Health
2.7.3.6.1.6. 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.)
2.7.3.6.1.7. Summarization of Linkages – new linkages, auto-assignments, choices, changes including reasons for change

2.7.3.6.2. Service Coordination Reports

2.7.3.6.2.1. Transportation Services – number of requests, number approved, location, complaints
2.7.3.6.2.2. Nurse Helpline Reports – Summary of number of calls, topic of calls, disposition and follow-up of calls. ROI (Return on Investment) calculation.

2.7.3.6.3. Provider Reports
2.7.3.6.3.1. Program Support Site Visits

a) Site Visits – number, location
b) Outcome – summary reports
c) PCCM Immunization Pay for Performance – number and location of sites outreach and assistance provided
d) Provider Recruitment – number, location, response

2.7.3.6.3.2. Monitoring

a) Site Visits – number, location
b) Program Compliance – Summary Reports
c) Administrative procedures – Summary Reports
d) Outcome and Quality Assurance – Summary Reports
e) Corrective Action – Summary reports
f) Monitoring staff monthly and weekly schedules
g) Accessibility Reports – findings, actions, and types of responses of phone monitoring

2.7.3.6.3.3. Provider Listing and Linkage Report

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

2.7.3.6.3.4. Annual Contract Status Report

a) 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 both PCCM.

2.7.5. Medical Home Contractor Action Plan

2.7.5.1. The Program Administrator will develop and implement a Medical Home action plan. The Medical Home action plan shall be updated annually. The Medical Home 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.

2.7.6. Provider Participation Goals:

2.7.6.1. 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);

2.7.6.2. Goal 2: Increase the statewide number of participating PCCM PCP's by two (2%) in contract year two, and contract year three, and one (1%) in contract years four and five. Each measurement year shall be compared to the prior year.

2.7.6.3. 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.

2.7.7. Member Access to Services Goals:

2.7.7.1. 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;

2.7.7.2. Goal 5:Increase the total number of Medicaid Enrolled children receiving one (1) annual EPSDT preventive medical screen by one (1%) in contract year one, and two (2%) in each subsequent contract year. Each measurement year to be compared to prior year;

2.7.7.3. Goal 6: Increase the percentage of Medicaid Enrolled children identified as needing EPSDT medical screening service(s) who receive the needed medical screening service(s) by one (1%) percent in contract year one, and two (2) percent in each subsequent contract year. Each measurement year is to be compared to prior year. Method(s) of identification and measurement shall be determined and agreed upon by the Department and the Program Administrator.

2.7.7.4. 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.

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

2.7.7.6. 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.

2.7.7.7. Medical Home action plan goals shall be measured in a manner determined and agreed upon by the Department and the Program Administrator once the Medical Home action plan is approved. The Department will provide a copy of outcome measure reports and analyses to the Program Administrator.

2.7.7.8. The annual Medical Home 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 Medical Home

action plan shall be submitted to the Department June 30 of each contract year and approved by the Department prior to implementation by the Proposer. A Medical Home action plan status report shall be submitted to the Department no later than January 31 of each contract year. An annual Medical Home action plan final outcome report shall be submitted to the Department no later than August 31 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 Program Administrator once the Medical Home action plan is approved.

2.7.8. Meetings

2.7.8.1. Regular meetings will be scheduled by the Department with the Program Administrator. The Program Administrator 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 Program Administrator will be responsible for the meeting summary preparation and distribution and obtaining approval from the Department.

2.7.9. Contract Monitoring

2.7.9.1. The Medical Vendor Administration (Medicaid) establishes the policy and procedural requirements which PCCM providers must follow. DHH will assign a Contract Monitor, over all liaison and point of contact between the Department the Program Administrator, 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.

2.7.9.2. The Program Administrator 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 this 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.

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

2.7.9.4. To perform the functions of the contract adequately, interaction between the MMIS systems and Program Administrator 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 Program Administrator will provide computer and networking equipment required to input and access data as specified by the Fiscal Intermediary and approved by the Department.

2.7.9.5. A detailed current description of PCCM services and provider requirements is contained in the PCCM Handbook and the 2007 Unisys PCCM Provider Training Packet. (This information is available in the Procurement Library , Department Website and the Louisiana PCCM website).

2.7.10. Invoices

2.7.10.1. Invoices are due to the Contract Monitor no later than the tenth (10th) of the month following the month of rendering the invoiced services.

2.7.10.2. Invoices must be separated by contract category with Department cost centers identified and Federal/State match rate identified as directed by the Department.

2.7.11. Liquidated Damages

2.7.11.1. 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.

2.7.11.1.1. Late submission of required reports - $50.00 per working day, per report.

2.7.11.1.2. Failure to fill vacant contractually required key staff positions within 60 days - $500.00 per working day from 61st day of vacancy until filled with an employee approved by the Department.

2.7.11.1.3. 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.

2.7.11.1.4. Failure to comply with call center requirements as specified in the RFP or as agreed to by the Department - $200 per occurrence.

2.7.11.1.5. Inaccuracies in the EPSDT Screening provider Enrollment Agreements approved by the Program Administrator - $100 per occurrence.

2.7.11.1.6. Failure to comply with enrollment broker requirements as specified in the contract - $200 per occurrence.

2.7.11.1.7. Failure to meet goals in the approved Action Plan Member- $10,000 each year percentages not met.

2.7.11.1.8. Failure to comply with certification and monitoring deliverables- $200 per occurrence.

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

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

2.7.12. Incentive Payments for Action Plan Goals

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

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

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

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

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

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

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

2.7.13. Subcontracting

2.7.13.1. 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:

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

2.7.14. Insurance Requirements

2.7.14.1. 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.

2.7.14.2. Contractor's Insurance

2.7.14.2.1. 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.

2.7.14.3. Compensation Insurance

2.7.14.3.1. 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.

2.7.14.4. Commercial General Liability Insurance

2.7.14.4.1. 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.

2.7.14.5. Insurance Covering Special Hazards

2.7.14.5.1. 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.

2.7.14.6. Licensed and Non-Licensed Motor Vehicles

2.7.14.6.1. 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.

2.7.14.7. Subcontractor's Insurance

2.7.14.7.1. 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.

2.7.15. Resources Available to Contractor

2.7.15.1.1. 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.

2.7.16. Contact Personnel:

2.7.16.1.1. All work will be performed under the direct supervision of:

Angela Mastainich
Contract Monitor
Medical Vendor Administration
Program Operations
Bienville Building, 7th Floor
628 North 4th Street

Baton Rouge, LA 70821

2.7.17. Term of Contract

2.7.17.1. The contract shall commence on or near the date approximated in the Schedule of Events. 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.

2.7.18. Deliverables

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

3. Proposals

3.1. General Information

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

3.1.2. Proposals should address how the Proposer intends to assume complete responsibility for timely performance of all contractual responsibilities in accordance with federal and state laws, regulations, policies, and procedures.

3.2. Procurement Library / Resources Available to Proposer

3.2.1. Department program manuals and pertinent Federal and State regulations, as well as other pertinent materials, are available for review upon request in the Procurement Library. Relevant material related to this RFP will be posted at the following web address:

http://www.dhh.louisiana.gov/publications.asp?ID=1&CID=25

3.2.2. General information regarding the Louisiana Medicaid Program is available at the following web address: www.medicaid.dhh.louisiana.gov

3.3. Proposal Submission

3.3.1. All proposals must be received by the due date and time indicated on the Schedule of Events. Proposals received after the due date and time will not be considered. It is the sole responsibility of each Proposer to assure that its

proposal is delivered at the specified location prior to the deadline. Proposals which, for any reason, are not so delivered will not be considered.

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

3.3.3. If delivered by Courier or hand delivered:

Mary Gonzalez
DHH Division of Contracts and Procurement Support
628 N. 4th St.
5th Floor
Baton Rouge, LA 70802

3.3.4. If delivered by regular mail:

Mary Gonzalez
DHH Division of Contracts and Procurement Support
P.O. Box 1526
Baton Rouge, LA 70821-1526

3.3.5. Proprietary and/or Confidential Information

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

3.3.5.2. For the purposes of this RFP, the provisions of the Louisiana Public Records Act (La. R.S. 44.1 et. seq.) will be in effect. Pursuant to this Act, all proceedings, records, contracts, and other public documents relating to this RFP shall be open to public inspection. Proposers are reminded that while trade secrets and other proprietary information submitted in conjunction with this RFP may not be subject to public disclosure, protections must be claimed by the proposer at the time of submission of its Technical Proposal. Proposers should refer to the Louisiana Public Records Act for further clarification.

3.3.5.3. The proposer must clearly designate the part of the proposal that contains a trade secret and/or privileged or confidential proprietary information as "confidential" in order to claim protection, if any, from disclosure. The proposer shall mark the cover sheet of the proposal with the following legend, specifying the specific section(s) of the proposal sought to be restricted in accordance with the conditions of the legend:

3.3.5.3.1. *"The data contained in pages _____of the proposal have been submitted in confidence and contain trade secrets and/or privileged or confidential*

information and such data shall only be disclosed for evaluation purposes, provided that if a contract is awarded to this Proposer as a result of or in connection with the submission of this proposal, the State of Louisiana shall have the right to use or disclose the data therein to the extent provided in the contract. This restriction does not limit the State of Louisiana's right to use or disclose data obtained from any source, including the proposer, without restrictions."

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

3.3.5.5. Proposers must be prepared to defend the reasons why the material should be held confidential. If a competing proposer or other person seeks review or copies of another proposer's confidential data, DHH will notify the owner of the asserted data of the request. If the owner of the asserted data does not want the information disclosed, it must agree to indemnify DHH and hold DHH harmless against all actions or court proceedings that may ensue (including attorney's fees), which seek to order DHH to disclose the information. If the owner of the asserted data refuses to indemnify and hold DHH harmless, DHH may disclose the information.

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

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

3.4. Proposal Cost

3.4.1. The Proposer assumes sole responsibility for any and all costs associated with the preparation and reproduction of any proposal submitted in response to this RFP, and shall not include this cost or any portion thereof in the proposed contract price.

3.5. Ownership of Proposal

3.5.1. All proposals become the property of the Department and will not be returned to the Proposer. The Department retains the right to use any and all ideas or adaptations of ideas contained in any proposal received in response to this solicitation. Selection or rejection of the offer will not affect this right. Once a contract is awarded, all proposals will become subject to the Louisiana Public Records Act.

3.6. Certification Statement

3.6.1. The Proposer must sign and submit the attached Certification Statement.

3.7. Proposal Submission

3.7.1. This section outlines proposal provisions that determine compliance of each Proposer's response to the RFP. Failure to comply with any mandatory requirement shall result in the rejection of the proposal. The agency shall determine, at its sole discretion, whether or not the RFP provisions have been reasonably met. The proposal should describe the background and capabilities of the Proposer, give details on how the services will be provided, and must include a breakdown of proposed costs. It should also include information that will assist the Department in determining the level of quality and timeliness that may be expected. Work samples may be included as part of the proposal.

3.7.2. An Item-by-item response to the Request for Proposals is requested.

3.7.3. There is no intent to limit the content of the proposals, and Proposers may include any additional information deemed pertinent. Emphasis should be on simple straightforward and concise statements of the Proposer's ability to satisfy the requirements of the RFP. Innovative approaches are encouraged.

3.7.4. Oral Presentations: The Department may select the three top scoring finalists for an oral presentation for final determination of contract award. Oral presentations will allow Proposers to demonstrate the resources that will be utilized to carry out the services that are proposed in the RFP.

3.8. Requested Proposal Outline

3.8.1. Introduction
3.8.2. Understanding of Project Scope
3.8.3. Work Plan
3.8.4. Relevant Corporate Experience
3.8.5. Corporate Financial Condition
3.8.6. Personnel Qualifications
3.8.7. Cost and Pricing Analysis
3.8.8. Administrative Data
3.8.9. Assignments
3.8.10. Additional Information
3.8.11. Warranty Against Cost Disclosure and Broker Fees
3.8.12. Location of Active Office with Full Time Personnel

3.9. Content of Proposal Outline Listed Above

3.9.1. Introduction

3.9.1.1. The introductory section should contain summary information about the Proposer's organization and its ability to satisfy provisions of the Request

for Proposal. This section should also include an organizational chart displaying the Proposer's overall structure.

3.9.2. Understanding of Project Scope, Needs, and Objectives

3.9.2.1. This section should state Proposer's knowledge and understanding of the needs and objectives of the Department as related to the scope of this RFP. The Proposer should relate this knowledge and understanding to the overall scope of services as requested in this RFP, including knowledge of DHH, and Medicaid. This section should contain work statements setting out the Proposer's management philosophy including, but not limited to, the role of Quality Control, Professional Practices, Supervision, Distribution of Work and Communication Systems.

3.9.2.2. The practicality of the execution of each stage of the project will be examined. The Proposer should provide a detailed breakdown of how the requested services will be provided. The rationale and methodology for achieving objectives will be considered as well as the Proposer's organizational approach to the project. Proposals should define Proposer's functional approach in providing services and identify the tasks necessary to meet the RFP requirements.

3.9.2.3. In the proposal, the Proposer should describe successful strategies it has used in other projects and venues that may be appropriate in Louisiana to increase Provider participation, particularly in rural areas, or for specialty care.

3.9.3. Work Plan/Project Execution

3.9.3.1. The Proposer should state the approach it intends to use to achieve each objective of the project including major activities and methodologies utilized for each work statement, as well as Department involvement. The Proposal should state how each objective of the project will be accomplished.

3.9.3.2. The work plan for project execution should include detailed information and or strategies related to the development and implementation of each deliverable as outlined in Section 2: Scope of Work.

3.9.3.3. This section should address the project work plan and provide a work schedule for each phase of the project. The work plan should be presented as follows:

3.9.3.3.1. Provide a written discussion of the work plan addressing process flow, time frames for each component; how findings will be addressed in the process; and the ability to maintain the work plan schedule (i.e. drawing on firm resources, training, etc.).

3.9.3.3.2. Provide a strategic overview including all elements to be provided.

3.9.3.3.3. Breakdown into logical tasks and time frames all work to be performed, accompanied by an assessment of relative difficulty for each task.

3.9.3.3.4. Identify critical tasks;

3.9.3.3.5. Estimate time involved in completion of tasks;

3.9.3.3.6. Identify all assumptions or constraints on tasks;

3.9.3.3.7. Refer to specific documents and reports that are to be produced as a result of completing tasks. Contain a summary, at the activity level, to show completion schedules relative to deliverables.

3.9.3.3.8. Include charts and graphs which reflect the work plan in detail.

3.9.3.3.9. Describe the approach to Project Management and Quality Assurance.

3.9.3.3.10. Discuss what flexibility exists within the work plan to address unanticipated problems which might develop during the contract period.

3.9.3.3.11. If the Proposer intends to subcontract for portions of the work, the Proposer should include specific designations of the tasks to be performed by the subcontractor.

3.9.3.3.12. Document procedures to protect the confidentiality of records in DHH databases, including records in databases that may be transmitted electronically via e-mail or the Internet.

3.9.3.3.13. A takeover/ transition plan which outlines the procedures and timelines to ensure continuity of services in the event of contract termination or award of contract to another vendor. The takeover/ transition plan must include procedures that shall, at a minimum, comply with the stipulations listed in **Section 2.6.1.13** of this RFP.

3.9.4. Relevant Corporate Experience

3.9.4.1. The proposal should indicate the firm has a record of prior successful experience in the design and implementation of the services sought through this RFP. Proposers should include statements specifying the extent of responsibility prior projects and a description of the projects scope and similarity to the projects outlined in this RFP. All experience under this section should be in sufficient detail to allow an adequate evaluation by the Department. In particular, the Proposer should demonstrate experience with the implementation of Medicaid contracts, call centers, PCCM programs, as well as enrollment broker's services. The Proposer should have, within the last 24 months, completed a similar type project. Proposers should give at least two customer references for projects completed in at least the last 24 months. References should include the name and telephone number of each contact person.

3.9.4.2. In this section, a statement of the Proposer's involvement in litigation that could affect this work should be included. If no such litigation exists, Proposer should so state.

3.9.5. Corporate Financial Condition

3.9.5.1. The organization's financial solvency will be evaluated. The Proposer's ability to demonstrate adequate financial resources for performance of the contract or the ability to obtain such resources as required during performance under this contract will be given special emphasis.

3.9.5.2. Proposal should include for each of the last three (3) years, copies of financial statements, preferably audited, including at least a balance sheet and profit and loss statement, or other appropriate documentation which would demonstrate to the Department the Proposer's financial resources sufficient to conduct the project.

3.9.6. Personnel Qualifications

3.9.6.1. This section should include the key factors which the Proposer understands shall be considered in the staffing and management of the project.

3.9.6.2. The purpose of this section is to evaluate the relevant experience, resources, and qualifications of the proposed staff to be assigned to this project. The experience of Proposer's personnel in implementing similar services to those to be provided under this RFP will also be evaluated. Proposer should also include a statement of its ability to commit full time key personnel for the full term of the contract and its plan for doing so. The adequacy of personnel for the proposed project team will be evaluated on the basis of project tasks, allocation of staff, professional skill mix, and level of involvement of personnel. Personnel should be identified, and should be the individuals who will work directly on the project. Percentage of time, work-hours committed or other identification of the proposed level of effort should be submitted.

3.9.6.3. Job descriptions for all staff referenced in this RFP shall be included and should indicate minimum education, training, experience, special skills and other qualifications for each staff position as well as specific job duties identified in the proposal. Proposers should also state job responsibilities, workload and lines of supervision. An organizational chart identifying individuals and their job titles and major job duties as well as indication of full- or part-time participation should be included. The organizational chart should show lines of responsibility and authority. The Proposer should clearly show how the organizational structure is designed to carry out the responsibilities within each of the major components.

3.9.6.4. Key personnel should be designated as such in the proposal, and résumés of all known personnel should be included. Resumes of key personnel proposed should include, but not be limited to:

3.9.6.4.1. Experience with Proposer,
3.9.6.4.2. Previous experience in projects of similar scope and size.
3.9.6.4.3. Where personnel have previously worked as a team on similar projects, résumé data should include responsibility and position within the team.
3.9.6.4.4. Educational background, certifications, licenses, special skills, etc.

3.9.6.5. If subcontractor personnel will be used, the Proposer should clearly identify these persons and provide the same information requested for the Proposer's personnel.

3.9.7. Cost and Pricing Analysis

3.9.7.1. Proposer must specify a total cost for performance of tasks and methodologies of payment. The cost proposal must be presented on an annual basis for each year of the contract, concluding with the total cost over the term of the contract. Proposal must include all anticipated costs of successful implementation of all deliverables outlined. An item by item breakdown of costs must be included in the proposal. The itemized cost breakdown must include, at the minimum, the cost for the following:

3.9.7.1.1. Call center functions
3.9.7.1.2. Monitoring activities
3.9.7.1.3. Enrollment broker activities
3.9.7.1.4. Outreach and Education
3.9.7.1.5. Recruiting
3.9.7.1.6. Information Technology functions

3.9.8. Administrative Data

3.9.8.1. The proposal shall include the following administrative data:

3.9.8.1.1. Name and address of principal officer;
3.9.8.1.2. Name and address for purpose of issuing checks and/or drafts;
3.9.8.1.3. For corporations, a statement listing name(s) and address (es) of principal owners who hold five percent interest or more in the corporation.
3.9.8.1.4. If out-of-state Proposer, give name and address of local representative; if none, so state;
3.9.8.1.5. If any of the Proposer's personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and social security number;
3.9.8.1.6. If the Proposer was engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state; and
3.9.8.1.7. Proposer's state and federal tax identification numbers.

3.9.8.2. The following mandatory administrative data shall also be included in this section:

3.9.8.2.1. Proposer shall guarantee that there will be no conflict or violation of the Ethics Code if it is awarded the contract. Ethics issues are interpreted by the Louisiana Board of Ethics.
3.9.8.2.2. Proposer shall guarantee that the entire proposal will be valid for a period of 120 days after the submission date
3.9.8.2.3. Proposer shall guarantee that the proposal submitted shall become a contractual obligation and valid if a contract is awarded.

3.9.9. Assignments

3.9.9.1. Any assignment, pledge, joint venture, hypothecation of right or responsibility to any person, firm or corporation should be fully explained and detailed in the proposal. Information as to the experience and

qualifications of proposed subcontractors or joint ventures should be included in the proposal. In addition, written commitments from any subcontractors or joint ventures should be included as part of the proposal.

3.9.10. Additional Information

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

3.9.11. Warranties

3.9.11.1. The following 2 items should be included in the proposal:

3.9.11.1.1. Warranty Against Cost Disclosure: The Proposer should warrant that it has not discussed or disclosed price or cost data with DHH prior to the opening of the proposal and that all price and/or cost data have been arrived at independently without consultation, communication or agreement with any competitor.

3.9.11.1.2. Warranty Against Broker's Fees: The Proposer should warrant that it has not employed any company or person other than a bona fide employee working solely for the Proposer or a company regularly employed as its marketing agent to solicit or secure the contract and should also warrant that it has not paid or agreed to pay any company or person other than the bona fide employee working solely for the Proposer as its marketing agent any fee, commission, percentage, brokerage fee, gifts, or any other consideration contingent upon or resulting from the award of the contract

3.9.12. Location of Active Office with Full Time Personnel

3.9.12.1. Include all office locations (address) with full time personnel.

3.9.13. Criteria for Evaluation

3.9.13.1. Evaluations will be conducted by a Proposal Review Committee.

3.9.13.2. Scoring will be based on a possible total of 100 points or a possible total of 110 points if DHH exercises the option for oral presentations. The proposal with the highest combined total score will be recommended for award.

3.9.14. Cost Evaluation:

3.9.14.1. The Proposer with the lowest total cost shall receive 25 points. Other Proposers shall receive points for cost based upon the following formula:

CPS = (LPC/PC)* 25

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

3.9.14.2. Additionally, a maximum of 10 points may be awarded for the cost criteria based on evaluation of reasonableness of cost based on economies of scale, adequate budget detail, and justification that all cost is consistent with the purpose, objectives, and deliverables of the RFP.

3.9.15. Evaluation Criteria

3.9.15.1. The following criteria will be used to evaluate proposals. The criteria and assigned weights are:

Evaluation Criteria	Point Total
Introduction/Understanding of Scope of Work	**5**
Work Plan/Project Execution	**30**
Corporate Experience/Financial Condition	**15**
Qualifications of Personnel	**15**
Cost	**35**
Total Points	**100**
Oral Presentations *(at the option of DHH)*	**10**
Maximum Points Possible	**110**

3.9.16. Announcement of Award

3.9.16.1. The Department will award the contract to the Proposer with the highest graded proposal and deemed to be in the best interest of the Department. All Proposers will be notified of the contract award. The Department will notify the successful Proposer and proceed to negotiate contract terms.

4. Other Information

4.1. Contact After Solicitation Deadline - After the date for receipt of proposals, no Proposer-initiated contact relative to the solicitation will be allowed between the Proposers and DHH until the award is made.

4.2. Rejection and Cancellation - Issuance of this solicitation does not constitute a commitment by DHH to award a contract or contracts. The Department reserves the right to reject any or all proposals received in response to this solicitation.

4.3. Completeness of Information – Failure to furnish mandatory information specifically required in this solicitation shall disqualify a proposal.

4.4. Award Without Discussion - The Secretary of DHH reserves the right to make an award without presentations by Proposers or further discussion of proposals received.

4.5. Retainage-The Department will secure a retainage of 10% from all billings under the contract as surety for performance. This retainage will be released on an annual basis upon determination of satisfactory job performance.

5. Contractual Terms

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

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

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

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

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

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

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

5.3.5. Board Resolution/Signature Authority: The Contractor, if a corporation, shall secure and attach to the contract a formal Board Resolution indicating the signatory to the contract is a corporate representative and authorized to sign said contract.

5.3.6. Warranty to Comply with State and Federal Regulations: The Contractor shall warrant that it shall comply with all state and federal regulations as they exist at the time of the contract or as subsequently amended.

5.3.7. Warranty of Removal of Conflict of Interest: The Contractor shall warrant that it, its officers, and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services hereunder. The Contractor shall periodically inquire of its officers and employees concerning such conflicts, and shall inform the Department promptly of any potential conflict. The Contractor shall warrant that it shall remove any conflict of interest prior to signing the contract.

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

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

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

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

Attachments:

I: Certification Statement
II: DHH Standard Contract Form (CF-1)
III: HIPAA

CERTIFICATION STATEMENT ATTACHMENT I

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

OFFICIAL CONTACT: The Department requests that the Proposer designate one person to receive all documents. Identify the Contact name and fill in the information below:

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

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

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

1. The information contained in its response to this RFP is accurate;

2. Proposer accepts the procedures, evaluation criteria, contract terms and conditions, and all other administrative requirements set forth in this RFP.

Authorized Signature: _____

Typed or Printed Name: _____

Title: _____

Company Name: _____

Attachment II

DHH - CF - 1

AGREEMENT BETWEEN STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

AND

FOR

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

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

9) **Brief Description Of Services To Be Provided:**
Include description of work to be performed and objectives to be met; description of reports or other deliverables and dates to be received (when applicable). In a consulting service, a resume of key contract personnel performing duties under the terms of the contract and amount of effort each will provide under terms of contract should be attached.

10) **Effective Date**	11) **Termination Date**

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**
If progress and/or completion of services are provided to the satisfaction of the initiating Office/Facility, payments are to be made as follows: (stipulate rate or standard of payment, billing intervals, invoicing provisions, etc.). Contractor obligated to submit final invoices to Agency within fifteen (15) days after termination of contract.

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

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

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

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

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

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

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

4. Contractor agrees to retain all books, records and other documents relevant to the contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 74:53 (b) whichever is longer. Contractor shall make available to the Department such records within thirty (30) days of the Department's written request and shall deliver such records to the Department's central office in Baton Rouge, Louisiana, all without expense to the Department. Contractor shall allow the Department to inspect, audit or copy records at the Contractor's site, without expense to the Department. If Medicare reimbursable, these shall be made available to the Secretary, U.S. DHHS and the U.S. Comptroller General, and their representatives to certify the nature and extent of costs of services, as provided at Section 2440.4 of the Provider Reimbursement Manual (HIM 15-1).

5. Contractor shall not assign any interest in this contract and shall not transfer any interest in the same (whether by assignment or novation), without written consent of the Department thereto, provided, however, that claims for money due or to become due to Contractor from

the Department under this contract may be assigned to a bank, trust company or other financial institution without advanced approval. Notice of any such assignment or transfer shall be promptly furnished to the State.

6. Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this agreement shall be Contractor's. The Contractor assumes responsibility for its personnel providing services hereunder and shall make all deductions for social security and withholding taxes, contributions for unemployment compensation funds, and shall maintain, at Contractor's expense, all necessary insurance for its employees, including but not limited to workers compensation and liability insurance.

7. In consideration for goods delivered or services performed, the Department shall make all checks payable to the Contractor in the amounts and intervals as expressed or specified in the agreement. In cases where travel and related expenses are required to be identified separate from the fee for services, such costs shall be in accordance with State Travel Regulations and are specified under "Special Provisions." The contract contains a maximum compensation which shall be inclusive of all charges including fees and travel expenses. When applicable, the amounts may be stated by category and then as a comprehensive total.

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

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

10. Upon completion of this contract or if terminated earlier, all records, reports, work sheets or any other materials related to this contract shall become the property of the Department.

11. Contractor shall not enter into any subcontract for work or services contemplated under this agreement without obtaining prior written approval of the Department (which approval shall be attached to the original agreement). Any subcontracts approved by the Department shall be subject to conditions and provisions as the Department may deem necessary; provided, however, that notwithstanding the foregoing, unless otherwise provided in this agreement, such prior written approval shall not be required for the purchase by the Contractor of supplies and services which are incidental but necessary for the performance of the work required under this agreement; and provided, further, however that no provisions of this clause and no such approval by the Department or any subcontract shall be deemed in any event or manner to provide for the incidence of any obligation of the Department beyond those specifically set forth herein. Further provided that no subcontract shall relieve the Contractor of the responsibility for the performance of any subcontractor.

12. Any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when reduced to writing, duly signed, and attached to the original of this agreement. No claim for services furnished or requested for reimbursement by Contractor, not provided for in this agreement, shall be allowed by the Department. This contract is not effective until approved by the required authorities of the Department and if contract exceeds $20,000, the Director of the Office of Contractual Review in accordance with La. R.S. 39:1502. It is the responsibility of Contractor to advise the agency in advance if contract funds or contract terms may be insufficient to complete contract objectives.

13. In the event the Department determines that certain costs which have been reimbursed to Contractor pursuant to this or previous agreements are not allowable, the Department shall have the right to set off and withhold said amounts from any amount due the Contractor under this agreement for costs that are allowable.

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

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

15. Any amendment to this agreement shall not be valid until it has been executed by the Undersecretary or Assistant Secretary or other designated authority of the Office which is a party to the contract, and the Contractor and approved by required authority of the Department; and; if contract exceeds $20,000, the Director of the Office of Contractual Review, Division of Administration. Budget revisions in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.

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

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

18. Contractor agrees that purchase of equipment under the terms of this agreement shall require prior approval of the Department and shall conform to bid and inventory

requirements as set forth in the Property Control Manual for Contracting Agencies and which comply with the Louisiana Procurement Code and property control regulations.

Any equipment purchased under this agreement remains the property of the Contractor for the period of this agreement and future continuing agreements for the provision of the same services. For the purpose of this agreement, equipment is defined as any tangible, durable property having a useful life of at least (1) year and acquisition cost of $250.00 or more. The Contractor has the responsibility to submit to the Program Office Contract Monitor an inventory list of DHH equipment items when acquired under the contract and any additions to the listing as they occur. Contractor agrees that upon termination of contracted services, the equipment purchased under this agreement reverts to the State. Contractor agrees to deliver any such equipment to the State.

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

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

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

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

CONTRACTOR		**STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS**	
CONTRACTOR			
SIGNATURE	**DATE**	Alan Levine	**DATE**
NAME			
TITLE			

HIPAA Business Associate Addendum:

This Business Associate Addendum is hereby made a part of this contract in its entirety as Attachment __ to the contract.

1. The U. S. Department of Health and Human Services has issued final regulations, pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), governing the privacy of individually identifiable health information. See 45 CFR Parts 160 and 164 (the "HIPAA Privacy Rule"). The Department of Health and Hospitals, ("DHH"), as a "Covered Entity" as defined by HIPAA, is a provider of health care, a health plan, or otherwise has possession, custody or control of health care information or records.
2. "*Protected health information*" ("PHI") means individually identifiable health information including all information, data, documentation and records, including but not limited to demographic, medical and financial information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual or payment for health care provided to an individual; and that identifies the individual or which DHH believes could be used to identify the individual.

   "*Electronic protected health information*" means PHI that is transmitted by electronic media or maintained in electronic media.

   "*Security incident*" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
3. Contractor is considered a Business Associate of DHH, as Contractor either: (A) performs certain functions on behalf of or for DHH involving the use or disclosure of protected individually identifiable health information by DHH to Contractor, or the creation or receipt of PHI by Contractor on behalf of DHH; or (B) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, financial or social services for DHH involving the disclosure of PHI.
4. Contractor agrees that all PHI obtained as a result of this contractual agreement shall be kept confidential by Contractor, its agents, employees, successors and assigns as required by HIPAA law and regulations and by this contract and addendum.
5. Contractor agrees to use or disclose PHI solely (A) for meeting its obligations under this contract, or (B) as required by law, rule or regulation or as otherwise permitted under this contract or the HIPAA Privacy Rule.
6. Contractor agrees that at termination of the contract, or upon request of DHH, whichever occurs first, Contractor will return or destroy (at the option of DHH) all PHI received or created by Contractor that Contractor still maintains in any form and retain no copies of such information; or if such return or destruction is not feasible, Contractor will extend the confidentiality protections of the contract to the information and limit further uses and disclosure to those purposes that make the return or destruction of the information infeasible.
7. Contractor will ensure that its agents, employees, subcontractors or others to whom it provides PHI received by or created by Contractor on behalf of DHH agree to the same restrictions and conditions that apply to Contractor with respect to such information. Contractor also agrees to take all reasonable steps to ensure that its employees', agents' or subcontractors' actions or omissions do not cause Contractor to breach the terms of this Addendum. Contractor will use all appropriate safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this contract and Addendum.

8. Contractor shall, within 3 days of becoming aware of any use or disclosure of PHI, other than as permitted by this contract and Addendum, report such disclosure in writing to the person(s) named in section 14 (Terms of Payment), page 1 of the CF-1.
9. Contractor shall make available such information in its possession which is required for DHH to provide an accounting of disclosures in accordance with 45 CFR 164.528. In the event that a request for accounting is made directly to Contractor, Contractor shall forward such request to DHH within two (2) days of such receipt. Contractor shall implement an appropriate record keeping process to enable it to comply with the requirements of this provision. Contractor shall maintain data on all disclosures of PHI for which accounting is required by 45 CFR 164.528 for at least six (6) years after the date of the last such disclosure.
10. Contractor shall make PHI available to DHH upon request in accordance with 45 CFR 164.524.
11. Contractor shall make PHI available to DHH upon request for amendment and shall incorporate any amendments to PHI in accordance with 45 CFR 164.526.
12. Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from or created or received by Contractor on behalf of DHH available to the Secretary of the U. S. DHHS for purposes of determining DHH's compliance with the HIPAA Privacy Rule.
13. Compliance with Security Regulations:

    In addition to the other provisions of this Addendum, if Contractor creates, receives, maintains, or transmits electronic PHI on DHH's behalf, Contractor shall, no later than April 20, 2005:

    (A) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of DHH;

    (B) Ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it; and

    (C) Report to DHH any security incident of which it becomes aware.
14. Contractor agrees to indemnify and hold DHH harmless from and against all liability and costs, including attorneys' fees, created by a breach of this Addendum by Contractor, its agents, employees or subcontractors, without regard to any limitation or exclusion of damages provision otherwise set forth in the contract.
15. Notwithstanding any other provision of the contract, DHH shall have the right to terminate the contract immediately if DHH determines that Contractor has violated any material term of this Addendum.