



# Provider Handbook

Dear Community Health Solutions of Louisiana Provider,

We are very glad you have joined our network of Primary Care Providers. We have consistently proven that, by allowing our PCPs to remain the driver of care for our members and by providing our PCPs with tools to manage those services, Community Health Solutions has facilitated the provision of quality care to our members and savings in other state programs and intends to accomplish the same quality care and saving for the state of Louisiana. Community Health Solutions of Louisiana (CHS-LA) is focused on four goals: 1) Improved Access to Care for our Members; 2) Improved Health Status of our Members; 3) Providing Helpful and Non-intrusive Support to our Providers; and 4) Reducing health care expenditures for our Members by providing timely and appropriate preventive care and disease management.

To achieve our goals, CHS-LA provides a dedicated, supportive Care Management Team for each of our providers. This team is composed of a Care Management Registered Nurse, a local Provider Services Representative and a telephonically-based Provider Call Center Representative. Our Care Management RN will work with you and your office staff to develop individualized Care Plans for your patients with a chronic or complex condition or who are identified as having or being at high risk for a chronic or complex condition and to assist you on educating and supporting your patients. Our local Provider Services Representative will meet with you regularly to make you aware of any upcoming program changes, to address any concerns regarding CHS-LA program or members, and to review the CHS-LA generated reports designed to help you better manage the care for enrolled members. In addition, your dedicated telephonic Provider Call Center Representative will contact you regularly to ensure that we have up-to-date, accurate information regarding you and your practice partners and office hours and they will be available to facilitate resolutions of program-related issues as they arise. We hope that, through the development of this relationship, you will become comfortable with and reliant on the Care Management services offered through CHS-LA so that we become lasting partners as we work to help our Members make improvements in their health status.

We also hope that this Provider Manual will function as an easy resource for you regarding CHS-LA's program, policies, and procedures. We view this manual as a working document and our Provider Representatives will bring you updated materials when they make their quarterly visits.

Again, thank you for joining our network of providers. We look forward to working with you as we continue to serve Louisiana's Medicaid population.

*Community Health Solutions of Louisiana*

## **CHS-LA Contact Information**

If you need to contact CHS-LA with any questions or concerns, please see contact information below:

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## Coordinated Care Network- Shared Savings Overview

The Coordinated Care Network- Shared Savings (CCN-S) program is a Primary Care Case Management (PCCM) model of care. The PCCM model of care is based on a primary care provider network through which the primary care providers/practices (PCPs) provide their patients a medical home. In the medical home, patients receive the majority of their healthcare services as well as obtaining referrals for specialty care. A PCCM is a network of Medicaid primary care providers—not a prepaid health maintenance organization (HMO). The PCCM model is built upon the basic belief that Medicaid members who receive appropriate and timely primary and preventive care services in an on-going stable setting are less likely to utilize higher cost settings for episodic care. This, in turn, improves the overall quality of care for the Members, reduces recidivism in chronic care management, and helps Medicaid members better learn how to use limited healthcare services.

The expected outcomes of the CCN-S program include providing:

- Improved coordination of care
- A patient-centered medical home for Medicaid recipients
- Better health outcomes
- Increased quality of care
- Greater emphasis on disease prevention and management of chronic conditions
- Earlier diagnosis and treatment of acute and chronic illness
- Improved access to medically necessary specialty care
- Promotion of healthy behaviors through outreach and education
- Increased personal responsibility and improved self-management among members
- A reduction of avoidable hospitalizations and readmissions
- A decrease in fraud, abuse and wasteful spending
- Increased accountability for expenditures
- Improved financial sustainability
- Savings to the State as compared to the existing Fee-for-Service Medicaid delivery system

## **Community Health Solutions of Louisiana (CHS-LA)**

*Improving the Health of Louisiana . . . One Member at a Time*

Community Health Solutions of Louisiana (CHS-LA) is a Coordinated Care Network (CCN) that is patient-centered and provider-driven. Our program is built on the basic principle that the Primary Care Provider should be allowed to practice medicine and that our role is to support our network providers through Care Management support and robust reporting. Our company has successfully managed a Shared Savings program in other states since 2005. We have been successful in improving access to and quality of care and realizing consistent cost savings while maintaining high satisfaction among our members and providers.

Our program utilizes a robust Care Management Information System and certified Care Management Registered Nurses to identify and support members with or at risk for chronic health conditions. The goal of our Care Management Department is to offer members education and a support system that will help them assume greater responsibility for their health and make better health care and lifestyle decisions. In addition to supporting members, we are also here to help support medical care providers and their staff. We want you to consider our Care Management Department as an extension of your office. We want to assist you in the coordination of care and education of our members. Additionally, we will provide you with data that will assist you in managing the health care offered to our members.

This provider handbook provides guidance related to the CHS-LA CCN program requirements and can be accessed via our website, along with associated provider policies and procedures at [louisiana.chsamerica.com](http://louisiana.chsamerica.com). This manual can be requested hardcopy via telephone at (855) 247-5248 or through our website at [louisiana.chsamerica.com](http://louisiana.chsamerica.com).

## **Providers' Bill of Rights**

Each network-enrolled provider who contracts with CHS-LA to furnish services to the members shall be assured of the following rights:

- A Health Care Professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a member who is his/her patient, for the following:
  - The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered.
  - Any information the member needs in order to decide among all relevant treatment options.
  - The risks, benefits and consequences of treatment or non-treatment.
  - The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment and to express preferences about future treatment decisions.
- To receive information on the Grievance, Appeal and Fair Hearing procedures.
- To have access to the CHS-LA's policies and procedures covering the authorization of services.
- To be notified of any decision by CHS-LA to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested.
- To appeal, on behalf of a Medicaid/CHIP member to a State Fair Hearing, CHS-LA's action to deny, reduce or suspend medically necessary services.
- The CHS-LA provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- To be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification.
- To dispute any issue or dispute that arises between a provider and CHS-LA that is not the result of a provider acting on behalf of an enrollee in the grievance and appeal process and is related to unique administrative functions of CHS-LA.

## Members' Bill of Rights

Each member and potential member is guaranteed the following rights:

- To be treated with respect and dignity
- To have your privacy protected
- To take part in decision making about your health care
- The right to refuse treatment or services
- To refuse any health service based on your religious beliefs
- To obtain a second opinion, at no cost. Your PCP can arrange this for you
- To be free from any form of restraint or seclusion used as a means of pressure, discipline, convenience or punishment
- To be able to request and receive a copy of his/her medical records (one copy free of charge)
- To ask that your records be changed or corrected if needed.
- To receive health care services available to you through your state plan, including services for special health care needs
- To receive health care services that are easy to get and do what they are supposed to do
- To not be denied services because of diagnosis, type of illness, or medical condition
- To receive information in a way you can understand
- To receive assistance from DHH and Maximus (Enrollment Broker) in understanding your health plan
- To receive oral interpretation services free of charge if you do not speak English
- To be told that oral interpretation is available and how to get those services
- As a potential member, you can receive information about the basic features of the CCN program, including
  - Who may or may not enroll in the program
  - The CCN program's duties for coordinating care in order for you to make an informed choice in a timely manner
- To receive information on the CCN's services, including, but not limited to:
  - Benefits covered and how to get them
  - Authorization requirements
  - Any cost sharing requirements
  - Service area
  - Names, locations, telephone numbers of doctors that speak a language other than English
  - Any limits on your freedom to choose a doctor
  - Doctors not taking new patients
  - Benefits not offered and how to get them, including how transportation is provided
- To get a copy of your disenrollment rights, at least once a year
- To get notice of any big change in your benefits at least 30 days before they happen.
- To get information on grievance, appeal and State Fair Hearing procedures
- To get information about emergency and after-hours coverage, to include, but not limited to:
  - What an emergency medical condition, emergency services, and post-stabilization services are

- That emergency services do not require prior authorization
- How to get emergency services
- Where to go for emergency services
- Your right to use any hospital or other setting for emergency care
- Post-stabilization care services rules
- To apply these rights without fear of being treated differently. To voice your wishes about future treatment if you became disabled.
- To get CHS-LA CCN'S policy on referrals for services not supplied by your doctor
- To get the following information when you ask:
  - Information on how CHS-LA works
  - Physician incentive plans
  - Service utilization policies
- To report to DHH if you feel your CCN has marketed to you in a wrong way (see form at the back of this handbook).

## **Member Enrollment**

The Enrollment Broker is responsible for assisting Medicaid members choose a plan. The Enrollment Broker will inform members of all CCNs in their GSA and will also assist the member in identifying in which plans their existing health care providers participate.

If a member fails to choose a plan within thirty (30) calendar days from the postmark date that an enrollment letter was sent, that member will be assigned to a plan by the Enrollment Broker. Whenever possible, the Enrollment Broker will assign the member to a plan that includes the member's historic provider, as identified by linkage or Medicaid claims history. If a provider contracts with more than one (1) CCN, the Enrollment Broker will assign members linked with that provider to CCNs with whom the provider contracts on a round robin basis.

Members have ninety (90) days after the postmark date of the Notice of Enrollment to change CCNs, without cause. Effective upon the ninety-first (91<sup>st</sup>) day, the member is "locked in" to the CCN for the remainder of the twelve (12) month enrollment period subject to DHH disenrollment provisions specified in section 10.1.11 of the RFP.

The Enrollment Broker will attempt to confirm a choice of PCP as well as CCN. If no PCP is chosen prior to assignment to a CCN, the CCN shall contact the member within ten (10) business days of receiving Member File from the Enrollment Broker to facilitate member choice of PCP. If a member does not proactively choose a PCP within ten (10) days of enrollment with a CCN, then the CCN shall assign the member to a PCP. As with the Enrollment Broker, the CCN shall attempt to link members to existing health care providers, based on linkage and Medicaid claims history.

## Primary Care Physician Requirements

A Primary Care Physician (PCP) is an individual physician or group medical practice that agrees to serve as the Member's primary physician, contribute to the development and implementation of a care treatment plan, when appropriate, and participate in quality of care initiatives and reviews. The PCP provides and/or arranges for the most of the members' healthcare needs. PCPs are required to either provide medically necessary services or authorize a timely referral to another provider to treat the member.

The following Medicaid provider types may enroll as a CCN-S Primary Care Provider:

- Family Medicine
- General Practice
- Pediatrician
- Internal Medicine
- OB/GYN
- Federally Qualified Health Centers (FQHC)
- Rural Health Clinics (RHC)

PCPs who enter into a contract with a CCN-S will be expected to meet certain conditions. The CCN-S will be responsible for ensuring that providers meet these conditions:

- The practice must be willing to accept new Medicaid patients not to exceed the practice's established capacity.
- The practice must provide primary care and patient care coordination services to each member.
- The practice must assist the member by providing systematic, coordinated care and will be responsible for all referrals for additional medically necessary care to other health care providers. Medically necessary services are defined by DHH as "Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: 1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and 2) not more costly than an alternative service or sequence of services at least as like to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary". The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing services at his discretion on a case-by-case basis."
- The practice must provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours a day, seven (7) days a week.
- The practice must provide preventive services as defined by the network.
- The practice must offer general patient education services to all members and potential members as well as disease management services to members for whom the services are appropriate.

- PCPs must establish and maintain hospital admitting privileges or enter into an arrangement with another physician or group practice for the management of inpatient hospital admissions of CCN members.
- The practice must follow the recommended Early and Periodic Screening Diagnosis, and Treatment (EPSDT) screening schedules, as required by the Centers of Medicare and Medicaid Services (CMS).

### **24-Hour Coverage Requirement**

PCPs are required to provide access to medical advice and care for enrolled members 24 hours per day, 7 days per week. There must be prompt, within thirty (30) minutes, access to a qualified medical practitioner who is able to provide medical advice, consultation, and authorization for service when appropriate. PCPs must have at least one telephone line that is answered by office staff during regular office hours.

PCPs must provide members with an after-hours telephone number. After-hours calls must be answered within thirty (30) minutes. The after-hours telephone number must connect the member to:

- An answering service that promptly contacts the PCP or the PCP- authorized medical practitioner; or
- A recording that directs the caller to another number to reach the PCP or the PCP- authorized medical practitioner; or
- A system that automatically transfers the call to a telephone line that is answered by a person who will promptly contact the PCP or the PCP – authorized medical practitioner; or
- A call center system; or
- The PCP's home telephone number, if he/she so chooses

A hospital may be used for the 24-hour telephone coverage requirement under the following conditions:

- The 24-hour access line is not answered by the emergency department staff.
- The PCP establishes a communication and reporting system with the hospital
- The PCP reviews results of all hospital-authorized services.

An office telephone line that is not answered after hours or answered with a recorded message instructing members to call back during offices hours or go to the emergency department for care is not acceptable. Returning after-hours calls outside of thirty (30) minutes is unacceptable. Additionally, it is not acceptable to refer members to a telephone number if there is no system in place, as outlined above, to respond to calls. PCPs are encouraged to refer patients with after-hours urgent medical problems to an urgent care center rather than the emergency room, provided there is one accessible to the members.

### **Standards of Appointment Availability**

PCPs must conform to the following standards for appointment availability:

- Emergency care – immediately upon presentation or notification
- Urgent care – within 24 hours of presentation or notification
- Routine sick care – within 3 days of presentation or notification
- Routine well care – within 45 days of presentation or notification (15 days if pregnant)

The PCP shall work with FFS provider to try and achieve the following:

- An initial appointment for prenatal visits for newly enrolled pregnant women within the following timetables:

- Within their first trimester within fourteen (14) days;
- Within the second trimester within seven (7) days;
- Within their third trimester within three (3) days; and
- High risk pregnancies within three (3) days of identification of high risk by the CCN PCP or maternity care provider, or immediately if an emergency exists
- An initial appointment for member who becomes pregnant shall be within 42 days.

### **Standards for Office Wait Time**

PCPs must conform to the following standards for office wait times:

- Walk-ins – within two hours or schedule an appointment within the standards of appointment availability listed above.
- Scheduled appointment – within 45 minutes
- Life – threatening emergency – must be managed immediately

### **Hospital Admitting Privileges Requirement**

PCPs must establish and maintain hospital admitting privileges or enter into a formal arrangement with another physician or group practice for the management of inpatient hospital admissions of CCN-S members. This requirement must be met prior to the PCP providing medical services to members. A voluntary written agreement between the PCP and a physician or group who agrees to admit CCN-S members for the PCP fulfills this requirement for participation. By signing such an agreement, the physician/group agrees to accept responsibility for admitting and coordinating medical care for the member throughout the member’s inpatient stay. This agreement must be completed by both parties. The Care Coordination Services Organization (CSO) must keep the original of this document on file. A sample admission agreement can be found in the Forms section. The following arrangement is acceptable:

- A physician, a group practice, a hospital group, a physician call group that is enrolled with the Louisiana Medicaid program, **and** has admitting privileges or formal arrangements at a hospital that is within 30 miles or 45 minute drive time from the PCP’s office. If there is no hospital which meets this geographic criteria, the closest hospital to the PCP practice is acceptable.

Hospital admitting agreements with unassigned call doctors are unacceptable.

### **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)**

PCPs are required to provide EPSDT screening to Medicaid-eligible children under the age of 21. The EPSDT standards are:

- To provide **EARLY** health assessments of the child who is Medicaid eligible so that potential diseases can be prevented.
- To **PERIODICALLY** assess the child’s health for normal growth and development.
- To **SCREEN** the child through simple test and procedures for conditions needing closer medical attention.
- To **DIAGNOSE** the nature and cause of conditions requiring attention, by synthesizing finds of the health history and physical examination.
- To **TREAT** abnormalities detected in their preliminary stages or make the appropriate referral whenever necessary.

The components of the required screening services are listed in the Louisiana Physicians provider manual.

The most current Recommended Childhood Immunization Schedule and EPSDT Screening Age Guidelines are available through the Centers of Disease Control and Prevention ([www.cdc.gov](http://www.cdc.gov)).

### **Adult Preventive Health Assessments**

PCPs are expected to provide all of the components of an initial preventive health assessment and periodic assessments to adult members age 21 and over. Adult physical examination guidelines are found in the Louisiana Physicians provider manual.

### **Women, Infants, and Children (WIC) Program Referrals**

Federal law mandates coordination between Medicaid Managed Care programs and the WIC program. PCPs are required to refer potentially eligible members to the WIC program. Sample copies of the WIC Referral Form and, the Medical Record Release form are available in the Forms section.

For more information, contact the local WIC agency.

### **Transfer of Medical Records**

PCPs must transfer the member's medical record to the receiving provider upon the change of the PCP and as authorized by the member within 30 days of the date of the request.

### **Coordination with FQHCs**

As established in Section 6.11 of the RFP, CHS-LA shall attempt to contract with all FQHCs and shall, in the cases of emergency services and when required for access to care, coordinate care with non-network FQHCs. CHS-LA shall expect non-network FQHCs to share information and data and to facilitate appropriate referrals in a timely manner.

## Medical Records Guidelines

1. Medical records should reflect the quality of care received by the patient/member in order to promote quality and continuity of care; the following guidelines are given as the standards for medical record keeping.
  - a. Each page, or electronic file in the record, contains the patient's name or patient's Medicaid identification number.
  - b. The primary language spoken by the member and any translation needs of the member.
  - c. Services provided must be documented with the date of service, service site, and the name of the service provider.
  - d. All entries are identified as to the author.
  - e. All entries are accurate.
  - f. The record is legible to someone other than the writer, including the author.
  - g. Medication allergies and adverse reactions are prominently noted and easily identifiable as well as the absence of allergies.
  - h. Personal and biographical data is recorded and includes age, date of birth, sex, address, employer, home and work telephone numbers, marital status and legal guardian (if applicable).
  - i. Past medical history is easily identified including diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, serious accidents, operations, and illnesses beginning with, at a minimum, the first member visit with or by the provider. For children, past medical history includes prenatal care and birth.
  - j. There is a completed immunization record. For pediatric patients (ages 12 and under) there is a complete record with dates of immunization administration.
  - k. Diagnostic information, medication, medical conditions, significant illnesses, and health maintenance concerns are recorded in the medical record.
  - l. Notation concerning smoking, alcohol, and other substance abuse is present.
  - m. Referrals are documented including follow-up and outcome of referrals. Notes from consultations are in the record. Consultation, lab, and X-ray reports filed in the chart have the ordering provider's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging results have an explicit notation in the record of the follow-up plans.
  - n. Signed and dated consent forms (as applicable).
  - o. Emergency care or after-hours encounters is documented in the record and follow up care.
  - p. Documentation of Advance Directives, as appropriate.
  - q. Discharge summaries are included as part of the medical record for all hospital admissions that occur while the patient is enrolled.

- r. Documentation of individual encounters that provide adequate evidence of appropriate history, physical examination, diagnosis, diagnostic tests, therapies, and other prescribed regimens, follow-up care, referrals and results thereof, and all other aspects of patient care, including ancillary services.
  - s. Each visit must include:
    - i. Date and begin and end times of service;
    - ii. Chief complaint or purpose of visit;
    - iii. Diagnoses or medical impression;
    - iv. Objective findings;
    - v. Patient assessment findings;
    - vi. Studies ordered and results of those studies (e.g., laboratory, x-ray, EKG);
    - vii. Medications prescribed;
    - viii. Health education provided;
    - ix. Name and credentials of the provider rendering services (e.g., MD, DO, OD) and the signature or initials of the provider; and
    - x. Initial of providers must be identified with correlating signatures.
  - t. EPSDT documentation requirements include the following:
    - i. Comprehensive health history;
    - ii. Developmental history;
    - iii. Unclothed physical exam;
    - iv. Vision, hearing and dental screening;
    - v. Appropriate immunizations;
    - vi. Appropriate lab testing including mandatory lead screening;
    - vii. Health education;
    - viii. Anticipatory guidance.
2. If the Quality Management Department becomes aware, through member complaint, LA DHH advisement, or other data sources, of a potential adverse pattern of quality of the care provided by a medical home provider/practice, CHS-LA may audit the medical records to ascertain the provider(s) compliance with these standards.
3. Medical Record Review:
- a. During the course of business, medical records may be secured by CHS-LA employees for various clinical functions.
  - b. A sample of the records will be reviewed by CHS-LA employees, who will use the medical record documentation audit tool and forward the findings in the Quality Management Department to maintain a database.
  - c. At any time, the Quality Management Department may request a random sample of records from a CHS-LA network provider to assess compliance with the documentation standards. These findings are also recorded in the Quality Management Department database.

- d. An on-site, random sampling, Medical Record Review will be conducted for all providers who have greater than 50 CHS-LA enrolled members assigned to their practice bi-annually.
  - e. Medical record reviews are conducted by appropriately trained care management, quality management, or provider services staff utilizing an established audit tool.
4. If an audited provider receives an overall result below the established benchmark, a quality of care case is opened per QM Policy and Procedure Quality Investigations. The aggregate findings of medical record documentation reviews are presented to the Quality Management Department for evaluation and intervention and, if necessary, referred to the Provider Advisory Committee. As part of the corrective action plan, feedback of the results of the audit will be discussed with the provider and education on the documentation standards will be provided. Once the intervention of education has taken place, the provider's medical records will, again, be audited for a re-measurement score with feedback of the results of the re-measurement audit score. Once an overall score consistent or exceeding the established benchmark is achieved, the provider may be randomly audited before the next annual review. Based on standards established by the 2011 Physician Quality Reporting System Measures Groups Specifications Manual by the Centers for Medicare and Medicaid Services, a minimum sample of 30 medical records will be reviewed annually.

## **PCP Referral Requirements**

Providers are required to provide timely and appropriate referrals for those services which do not require prior-authorization as outlined in the State Medicaid Plan. Referrals for service allow for appropriate care by specialty providers when that care or service cannot be administered by the PCP.

Referrals can be provided to the rendering practitioner either verbally or in writing. Referrals must be approved by the PCP and documented in the medical record. PCP is responsible to obtain results of evaluation, treatment or recommendations provided by referral practitioner / service provider as part of medical home oversight and care coordination. Any additional treatment or service indicated as a result of the referral should be implemented and / or monitored by the PCP.

Referrals are required for the following:

1. Specialty Physician
2. Hospitals
3. Lab
4. X-Rays
5. Ancillary service providers
6. Home health
7. Services provided through DHH Early Step Services
8. Dental Services
9. Personal Care Services (EPSDT and LT-PCS)
10. Intermediate Care Facilities for the Developmentally Disabled
11. Home and Community Based Waiver Services
12. School-based Individualized Education
13. Hospice Services
14. Non-Emergency Transportation
15. Nursing Facility Services
16. Pharmacy (Drug Prescriptions)
17. Specialized Behavioral Health Services
18. Targeted Case Management
19. Durable Medical Equipment
20. Prosthetics and Orthotics

## Utilization Management

DHH requires prior authorization of services as identified in the State Medicaid Plan. Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post-authorization (aka retrospective review). CCNS providers must follow those guidelines and obtain prior authorization for the required services, which include, but may not be limited to non-emergent admission, procedure or service.

Utilization Management (UM) criteria and practice guidelines are available upon request. Determinations of medical necessity will be performed by clinical staff appropriately trained in URAC, state and federal regulations.

Providers may submit prior authorization requests to the following:

1. Telephonically to 1-855-PRE-AUTH (1-855-773-2884)
2. Via fax at **877-448-8366**

CHS-LA, in accordance with federal and state regulations, may only provide service authorization for abortions in the following situations:

- If the pregnancy is the result of an act of rape or incest; or
- In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

**Prior Authorization** is defined as the process for authorization of services prior to the occurrence. This process includes:

- Determination of the medical necessity for hospitalization and/or surgical intervention utilizing approved review criteria.
- Determination of whether the requested service is a covered benefit.
- Decisions are made in a timely fashion for the member's condition, normally within two (2) business days of receipt of all of the appropriate medical information but not to exceed fourteen (14) days, unless an extension is requested by the Member or requesting provider.

**Concurrent Review** is defined as the process of determining continued authorization services during the course of those services (i.e. continued inpatient stay). This process includes:

- Determination of medical necessity of continued hospitalization utilizing approved review criteria.
- Identification of appropriate alternate levels of care.
- Early identification of discharge needs.
- Assuring efficient use of both Medicaid and community resources.
- Concurrent review service authorizations determination shall be made within one (1) business day of obtaining the appropriate medical information.

**Retrospective Review** (post authorization) is defined as review of any admission that the Plan or Plan designee is notified of, in accordance with the appropriate provider contract, but a review was not initiated or completed prior to the member's discharge. Decisions regarding services already delivered will be delivered within thirty (30) calendar days from receipt of the necessary medical information.

**Expedited Authorization Decisions** is for cases when a provider indicates that following the standard timeframe could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function, CHS-LA will make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the requested service. This may be extended up to fourteen (14) calendar days if the Member request's an extension.

### **Emergency Care and Post Stabilization Services**

CHS-LA does not require service authorization for emergency care or services required to stabilize the Member after emergency care is rendered. This includes a medical screening exam that is necessary to determine whether an emergency medical condition exists when a member seeks emergency room treatment. Necessary emergency care services will be provided including the treatment and stabilization of an emergency medical condition.

In addition to emergency care and post-stabilizations, service authorization is not required for the services listed below, however CHS-LA does request notification within forty-eight (48) hours of:

- Emergent inpatient admission.
- Non-emergent inpatient admission for normal newborn delivery.
- Continuation of medically necessary State Plan services of a new member transitioning into CHS-LA. Prior authorization will be requested if treatment extended beyond thirty (30) calendar days.
- Obstetrical care (at first visit).
- Obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery and ninety-six (96) hours after caesarean section.

### **Adverse Determinations**

Any denial of service for medical necessity is made by a Physician Reviewer. **Adverse Determination** is defined as a determination that the health care services furnished or proposed to be furnished to a patient are not medically necessary or appropriate. All adverse determinations must be rendered in accordance with all applicable State regulations. An **appeal** of adverse determination can be submitted, verbally or in writing, to the UM department by the Member or provider within thirty (30) calendar days of the determination.

### **Appeals**

The appeal review will be completed by a physician not involved in the initial adverse determination. Providers may request specialty review (a provider in same or similar specialty as typically manages situation) within ten (10) business days of receiving the appeal decision. The specialty review will be completed within fifteen (15) business days of request receipt.

The appeal resolution letter sent to the appealing party and applicable provider is sent no later than thirty (30) days after receipt of the appeal and includes:

- contractual reasons for the resolution
- clinical basis for the decision
- specialization of providers consulted
- notice of the right to have an Independent Review Organization (IRO) review the denial including IRO form
- CHS-LA toll free number and address

### **Expedited Appeals**

In the case of a life threatening condition or current hospitalization, and expedited appeal can be completed and will be reviewed by a physician not involved previously with the determination.

This physician/provider will be the same or similar specialty as would normally manage the condition under review. The expedited appeal will be completed based on the immediacy of the case, but no later than one (1) day from the date all information necessary to complete the appeal is received. Oral notification will be followed up by a letter in three (3) business days. The member is also entitled to immediate appeal to the IRO.

### **Independent Review of Adverse Determinations**

CHS-LA will facilitate the review by furnishing medical records, provider information, and other necessary documents to the IRO, in a timely manner. CHS-LA will comply with the IRO's determination and will reimburse the cost of the IRO review.

If the IRO upholds the denial, the member and provider will receive verbal notification and explanation of DHH State Fair Hearing process. Written notification of the determination along with process for requesting a state fair hearing will also be completed.

## **Claims Submission Requirements**

Claims for CHS-LA members must be filed with CHS-LA. Claims submitted directly to the Fiscal Intermediary (FI) for a CHS-LA member will be denied. CHS-LA accepts claim submission in electronic and paper formats. Claims are screened and preprocessed by CHS-LA claims staff and then forwarded to the Fiscal Intermediary (FI) for payment within two (2) business days of receipt of a clean claim. Claims with attachments are pre-processed and forwarded to the FI within a maximum of four (4) business days of receipt. In order to expedite the claim process, only clean claim should be submitted.

### **Timely Filing Guidelines**

CHS-LA encourages prompt submission of all claims, however claims must be submitted to CHS-LA *within 12 months* of the date of service.

### **Clean Claims**

*Providers are required to submit clean claims.* A “Clean Claim” means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State’s claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Claims are screened and preprocessed by CHS-LA claims staff and then forwarded to the Fiscal Intermediary (FI) for payment within two (2) business days of receipt of a clean claim. Paper claims with attachments are pre-processed and forwarded to the FI within a maximum of four (4) business days of receipt.

CHS-LA will adhere to the two (2) business day rule for submitting pre-processed clean claims to the FI, as the FI must adhere to prompt payment requirements established under the American Recovery and Reinvestment Act of 2009. This ensures that ninety percent (90%) of clean claims submitted for payment are paid to the provider within thirty (30) calendar days of receipt and ninety-nine-percent (99%) within ninety (90) calendar days.

### **Claim Submission Formats**

Claims for CHS-LA members must be filed with CHS-LA. Claims submitted directly to the Fiscal Intermediary (FI) for a CHS-LA member will be denied. CHS-LA accepts claim submission in electronic and paper formats. In order to expedite the claim process, only clean claim should be submitted.

All claims submitted to CHS-LA must comply with the following protocols and standards. Claims not meeting these standards may result in delayed payment or return of the claim to the provider for completion of missing or incomplete information.

Claims must be submitted to CHS-LA in one of the following formats:

- Electronic Claims Submission (EDI)
- CMS-1500 Form
- UB-04 Form
- ADA Form for dental claims
- State specific claim forms such as the KIDMED KM-3 Form

Clean claims must contain all of the information below:

Professional Services – CMS 1500 Form

- Recipient 13-digit Medicaid identification number
- Patient's Name
- Other Insurance Information must be completed if applicable
- Name of Referring Provider or Source – if applicable
- PCP's 7-digit referral authorization is required for all services requiring referrals
- Prior Authorization Number – if applicable
- Most current ICD-9 numeric diagnosis code, and narrative description if applicable
- Date(s) of Service
- Place of Service
- Procedure codes for services rendered (CPT, HCPCS, including modifier when applicable)
- Diagnosis Pointer indicating the most appropriate diagnosis for each procedure
- Usual and customary charges for each service rendered
- Number of units billed for each procedure code
- Total Charges
- Rendering Provider 7-digit Louisiana Medicaid Provider Number
- Rendering Provider National Provider Identifier (NPI) number
- Signature of Physician and Date (Signature stamps and computer-generated signatures are acceptable, but must be initialed by the practitioner or authorized representative)
- Billing Provider name, address including zip code, telephone number and NPI
- Billing provider's 7-digit Medicaid ID number

Additional documentation may be required in accordance with Louisiana Medicaid guidelines for certain claim situations.

Institutional Claims – UB04 Forms

- Provider Name, Address, Telephone#
- Type of Bill
- Beginning and ending service dates
- Patient's Name as listed on Medicaid eligibility card
- Patient's Address
- Patient's Birth Date
- Patient's Sex
- Admission Date (hospital services)
- Admission Hour (hospital services)
- Type of Admission (hospital services)
- Source of Admission (hospital services)
- Discharge Hour (hospital services)
- Patient Status (hospital services)

- Condition Codes (hospital services)
- Value Codes and Amounts
- Revenue Codes and Descriptions
- For outpatient services, Revenue codes require CPT/HCPCS procedure code when applicable based on the National Uniform Billing Standards.
- Service Date
- Units of Service
- Total Charges
- 10-digit National Provider Identifier (NPI)
- 7-digit Medicaid Provider Number
- Insured Name – as listed on Medicaid ID card
- Insured Unique ID / 13-digit Medicaid ID Number
- ICD-9 Principal diagnosis
- Attending physician name and/or number

Additional documentation may be required in accordance with Louisiana Medicaid guidelines for certain claim situations.

Electronic claims must be submitted in the standard HIPAA transaction formats.

Please refer to Louisiana Medicaid Provider Manuals for claims that must be billed using standardized paper billing forms.

All claims submitted to CHS-LA must comply with the following protocols and standards. Claims not meeting these standards may result in delayed payment or return to provider for completion of missing or incomplete information.

- All claims must contain:
  - The National Provider Identifier (NPI)
  - Provider Name
  - Provider 7-digit Louisiana Medicaid number
  - Recipient Medicaid identification number
- All required data fields must be completed, including the unique authorization number when applicable
- Standard procedural terminology is to be used (CPT, HCPCS, ICD-9, Revenue Codes)
- Electronic claims must be submitted in the standard HIPAA transaction formats.
- Paper claim submissions:
  - Original claim forms must be submitted for initial and resubmissions
  - Forms should be properly aligned in printer to ensure information is within the appropriate boxes
  - Use high quality printer ribbons and cartridges *in black ink*
  - Use font types Courier 12, Arial 11, or Times New Roman, font sizes 10-12
  - Do not use italic, bold, or underline features
  - Do not use marking pens. Use black ballpoint pen (medium ink)

- Do not use highlighters on claim forms. Simply circle specific sections that require special attention
- Do not submit carbon copies.
- All claims forms must be standard size of 8 ½” x 11”
- All claims with attachments must be submitted in hard copy and all attachment must be standard size of 8 ½” x 11”
- With the exceptions of the UB04 claim form, all other claim forms must be signed and dated. Stamped or computer-generated signatures are accepted but must be initiated by authorized personnel.
- Continuous feed forms must be torn apart before submission
- The recipient’s 13-digit Medicaid ID number must be indicated on all claims.

### **Returned Claims**

Claims that do not meet all standards for pre-processing will be returned to the provider along with a reject letter that sets forth the specific reason(s) why the claim is being rejected. CHS-LA will assist providers with obtaining required or missing information and resubmission of claims. A returned claim will not be reflected in the provider remittance advice because it will not have entered into the claims processing system

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM CODES BOARD

PUCA

FICA

1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input checked="" type="checkbox"/> TRICARE (TRICARE #) <input type="checkbox"/> CHAMPVA (Champion #) <input type="checkbox"/> GROUP HEALTH PLAN (Group #) <input type="checkbox"/> FECA (FECA #) <input type="checkbox"/> OTHER (Other #) <input type="checkbox"/>		1a. INSURED'S ID NUMBER 1234567891234	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doo, John E.		3. PATIENT'S BIRTH DATE 01:01:00 M X F	
5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE	
8. OTHER INSURED'S NAME (Last Name, F or M, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (State) YES NO c. OTHER ACCIDENT? YES NO	
9. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER	
12. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F		13. INSURED'S DATE OF BIRTH MM DD YY SEX M F	
14. EMPLOYER'S NAME OR SCHOOL NAME		16. EMPLOYER'S NAME OR SCHOOL NAME	
15. INSURANCE PLAN NAME OR PROGRAM NAME		17. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (Yes, return to and complete Part 9 & 6.)	
18. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED: _____ DATE: _____			
14. DATE OF CURRENT ILLNESS (For signature or injury (Accident or illness/condition)) MM DD YY		15. PATIENT HAS HAD SAME OR SIMILAR ILLNESS (SEE FIRST DATE) MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
15. RESERVED FOR LOCAL USE		19. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> \$ CHARGES _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Indicate items 1, 2, 3 or 4 to begin ICD-9 code) 1. 490 _____ 3. _____		22. MEDICAD RESUBMISSION CODE ORIGINAL REF. NO. _____	
24. A. (DATE)S OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES OR SUPPLIES (Specify Unusual Circumstances) E. DIAGNOSIS POINTER		23. PRIOR AUTHORIZATION NUMBER _____	
02 01 12 02 01 12 11		99213 1 120.00 1	
25. FEDERAL TAX ID NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? YES NO	
28. TOTAL CHARGE \$ 250.00		29. AMOUNT PAID \$ 0	
30. BALANCE DUE \$ 250.00		31. BILLING PROVIDER INFO & PH-F (004) 3053512	
32. SERVICE FACILITY LOCATION INFORMATION Pediatric Medical Clinic 501 Rue De Sante, Suite 9 Lafayette, LA 70088-6400		33. BILLING PROVIDER INFO & PH-F (004) 3053512	
34. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) D. Williams M.D. SIGNED: _____ DATE: _____		35. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED: _____ DATE: _____	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

## Marketing Limitations

Marketing, as defined in Section 11.1.1 of the CCN-Shared Savings request for Proposals (RFP), is “any communication for a CCN to a Medicaid eligible who is not enrolled in that CCN that can reasonably be interpreted to influence the recipient to 1) enroll in that particular CCN’s Medicaid product, or 2) either not enroll in, or disenroll from, another CCN’s Medicaid product.”

DHH has clear guidelines regarding allowable marketing activities and require prior approval of all marketing materials. In accordance with the Social Security Act §132 (d) and 42 CFR §438.104, all direct marketing to members or potential members shall be carried out by DHH or its designee and the CCN must assure DHH that marketing materials are accurate and do not mislead, confuse, or defraud the enrollee/potential enrollee. Copies of all marketing materials pertaining to CCN enrollment that the CCN or any of its subcontractors, including PCPs, plan to distribute must be approved by DHH prior to distribution.

Section 11.3 of the RFP specifically prohibits the CCN or any of its subcontractors from engaging in the following activities:

- Marketing directly or indirectly to Medicaid potential enrollees or CCN prospective enrollees, including persons currently enrolled in Medicaid or other CCNs, including direct mail advertising, “spam”, door-to-door, telephonic, or other “cold call” marketing techniques
- Asserting that the CCN is endorsed by CMS, the federal or state government or similar entity
- Distributing materials or making statements that DHH determines to be inaccurate, false, confusing, misleading, or intended to defraud members or DHH
- Portraying competitors in a negative manner
- Attaching a Medicaid application and/or enrollment form to marketing materials
- Assisting with enrollment or improperly influencing CCN selection
- Inducing or accepting a member’s enrollment or disenrollment
- Using the seal of the state of Louisiana, DHH’s name, logo, or other identifying marks on any materials produced or issued, without prior written consent by DHH
- Distributing marketing information (written or verbal) that falsely implies that members will be able to stay with their longtime doctor
- Distributing marketing information (written or verbal) that implies that joining CCNs or a particular CCN is the only means to preserving Medicaid coverage or that CCNs or a particular CCN is the only provider of Medicaid services and the potential enrollee must enroll in the CCN to obtain benefits or not lose benefits
- Comparing their CCN to another organization/CCN by name
- Sponsoring or attending marketing or community health activities or events without notifying DHH as specified in RFP
- Engaging in any marketing activity at an employer-sponsored enrollment event where employee participation is mandated by employer
- Offering any gifts or material with financial value or gain as incentive to or conditional upon enrollment. Promotional items must not exceed \$15 in value. Cash gifts, gift cards, or gift certificates or not permitted

- Making reference to any health-related rewards offered by the plan, such as monetary rewards for participation in smoking cessation, in pre-enrollment marketing materials
- Marketing or distributing marketing materials and soliciting members in any manner inside or within one hundred (100) feet of the following establishments: check cashing establishments, public assistance offices, DCFS eligibility offices for SNAP, FITAP, Medicaid Eligibility Offices, or Medicaid Application Centers
- Conducting marketing or distributing marketing materials in hospital emergency rooms, including the emergency room waiting areas, patient rooms, or treatment areas
- Releasing any report, graph, chart, picture, or other document produced in whole or in part relating to services provided under RFP on behalf of the CCN without prior written notice of DHH
- Purchasing/acquiring/using mailing lists of Medicaid eligibles from third party vendors including providers and state offices
- Using raffle tickets, event attendance, or sign-in sheets to develop mailing lists of prospective enrollees
- Charging members for goods or services distributed at events
- Charging members a fee for accessing CCN website
- Influencing enrollment in conjunction with the sale or offering of private insurance
- Using a personal or provider-owned communication device (telephone, fax machine, computer) to assist persons in enrolling in CCN
- Using terms that would influence, mislead or cause members to contact the CCN rather than the Enrollment Broker for enrollment
- Making charitable contributions or donations from Medicaid funds
- Referencing the commercial component of the CCN in any CCN enrollee marketing materials
- Using terms in marketing materials such as “choose”, “pick”, “join” unless the marketing materials include the Enrollment Broker’s contact information

In relation to Providers, Section 11.8 of the RFP requires that the CCN:

- Must acquire and file written consent of provider when conducting any marketing in a provider office
- May not require providers to distribute CCN-prepared communications to their patients
- May not provide incentives or giveaways to providers to distribute to CCN members or potential CCN members
- May not conduct member education in common areas of provider offices
- May not allow providers to solicit enrollment or disenrollment in a CCN or distribute CCN-specific materials at a marketing activity
- Must instruct providers that, if they wish to let their patients know of their CCN affiliations, they must inform patients of all CCNs with whom they contract
- Must instruct providers that, if they choose to display or distribute marketing or health education materials from CCNs they must display materials from all contracted CCNs

- Must instruct providers that they may inform patients of benefits, services and specialty care services offered by CCNs with whom they contract, but may not recommend one CCN over another, offer incentives for choosing one CCN over another, or assist the patient in deciding to select a specific CCN
- Upon termination with a CCN, a provider with contracts with other CCNs may notify patients of the change and the potential impact upon the patient.

## Contracting and Credentialing Process

For the CCN-S program, Community Health Solutions of Louisiana (CHS-LA) complies with the contractual requirements outlined in the contract between CHS-LA and the Department of Health and Hospitals (DHH) regarding the processing of provider contracts and credentials. CHS-LA secures a fully completed and executed contract for all participating providers. Provider contracts include the application for participation, the agreement for participation, and any attachments. CHS-LA request that providers utilize CAQH for submission of application whenever possible.

Upon receipt of a new provider contract, the Credentialing and Contract Assistant (CCA) will:

- Determine that the application is complete. If not, it shall be returned. Application and verification of provider data shall be carried out through CAQH database whenever possible. Providers must provide CHS-LA with their CAQH Provider Number and access to CAQH data. If a provider is unwilling/unable to utilize CAQH, a completed application must be submitted with the contract.
- Determine that each provider is enrolled with DHH as a Medicaid provider. If not, the application cannot be processed.
- Verify the National Provider Identifiers (NPI) numbers provided. If inaccurate, the application cannot be processed.
- Verify all provider addresses. If they cannot be verified, the application cannot be processed.
- For each practitioner submitted, complete the following:
  - Confirm Malpractice Insurance:
    - Each practitioner that treats members should be covered by a policy –either listed specifically by name or with a policy in which it is documented that all clinical staff are covered.
    - Evidence of malpractice insurance should include the name of the insured, the amounts of per incident and aggregate coverage, and the effective and expiration dates of coverage.
    - The initial malpractice document(s) is obtained by Provider Services at the time of the contract signing.
    - Renewal of malpractice document(s) notification will be sent to the provider’s office contact via email, phone or letter approximately sixty (60) days before expiration by the Credentialing Specialist with follow up as necessary to confirm renewal prior to expiration.
  - Confirm Hospital Privileges:
    - Verify that hospital privileges are listed for all practitioners on the application.
    - If hospital privileges are not listed, notify the Government Program Liaison, to have a “Hospital Admission Agreement/Formal Arrangement Form” completed.
  - Complete Licensure Verification–. If unable to verify current license, contract cannot be processed.
  - Review the Excluded Party List System. If a practitioner is on the Excluded Party List, contract cannot be processed.

- Access the HHS Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) website to ensure no sanctions exist for any of the practitioners listed on the application. If a practitioner is on the OIG’s LEIE, contract cannot be processed.
- If the contract can be processed, the CCA shall:
  - Ascertain the New Patient Indicator. The options for Indicator are:

**1 = Accepts All:**

- This practice accepts new member choices as well as new auto assigned members. There is no restriction on the selections.
- Member choice means the member calls DHH’s contracted Enrollment Broker and chooses CHS-LA and selects this practice as his/her medical home. Auto assignment means that the member did not return his/her enrollment package, qualifies for a managed care plan (CCN-S or CCN-P) and was assigned by the Enrollment Broker into CHS-LA and into the practice. The Enrollment Broker sends all auto-enrolled members a letter advising of their plan and practice assignment. As the practice accepts Member Choice, they will also accept members already with CHS-LA who want to transfer into the practice as their medical home.

**2 = Accepts None:**

- The practice does not accept any new members either through member selection or by auto-assignments.
- The practice does not accept any new members at all.
- If Accepts None is selected, Network Services must also advise as to whether the practice wants the “New Patient Override.”
- This field will work in conjunction with the New Patient Indicator and will advise Enrollment Broker if they are allowed to override the New Patient Indicator (and “push” members into a practice).
- This field was designed because of practices electing to be Accepts None, but still allow the members to be pushed in if they are already patients of the office who are newly qualifying for Medicaid. An override setting of YES will let Enrollment Broker override the system and put the patient in the practice even though they are Accepts None.

**3 = Member Choice Only:**

- The practice accepts only selections by member choice.
- Member choice means the member calls the Enrollment Broker and chooses CHS-LA and selects this practice as his/her medical home. The practice will also accept members who are already with CHS-LA who want to transfer from another medical home into this practice. The practice does not accept any auto-assigned members. Auto assignment means that the member did not return his/her enrollment package, qualifies for a managed care plan (CCN-S or CCN-P) and was assigned by the Enrollment Broker into CHS-LA and into the practice.

**4 = Member Choice with Family:**

- The practice accepts only selections by member choice only if a member of the family is already enrolled with the practice.
- If a member calls the Enrollment Broker and attempts to make a Member Choice into this practice, the Choice Counselor will confirm the enrolled family member prior to allowing enrollment by the member into the practice.
- This also means that a member cannot transfer into the practice without already having a family member in the practice. Simple Member Choice as listed in #3 above is not allowed. The practice does not accept any auto-assignments. Auto assignment means that the member did not return his/her enrollment package, qualifies for a managed care plan (CCN-S or CCN-P) and was assigned by the Enrollment Broker into CHS-LA and into the practice.

**5 = Auto-Assignment with Family:**

- The practice accepts only auto-assignments if a member of the family is already enrolled with the practice.
- The practice does not accept any Member Choices of any kind.
- This also means that a CHS-LA member cannot transfer from another medical home into this practice.

**6 = Auto-assignment Only:**

- The practice only accepts auto-assigned members.
- Auto assignment means that the member did not return his/her enrollment package, qualifies for a managed care plan (CCN-S or CCN-P) and was assigned by the Enrollment Broker into CHS-LA and into the practice. The Enrollment Broker sends all auto-enrolled members a letter advising of their plan and practice assignment.
- The practice does not accept any selections made by Member Choice.
- This also means that a CHS-LA member cannot transfer from another medical home into this practice.

**7 = Family Assign Only:**

- The practice accepts both Member Choice and Auto-Assignment if a member of the family is already enrolled with the practice.
  - Simple Member Choice as listed in #3 above is not allowed. Straight auto-enrollment as listed in #6 above is not allowed.
  - This also means that a member cannot transfer into the practice without already having a family member in the practice.
- Ascertain the Provider Capacity, ensuring it is within DHH guidelines of:
    - Physician-no more than 2,500 total Medicaid members
    - Physician Extender-no more than 1,000 total Medicaid members

## Grievance and Appeals

A grievance is defined as any expression of dissatisfaction of a member, primarily with regard to quality of care, access or administration of a policy. Providers may submit a grievance on behalf of the member. If the grievance results in an appeal with an adverse determination outcome, a provider may file an appeal on the members' behalf, with written consent from the member. During this process, the member, or provider on their behalf, may request continuation of service.

A provider can submit a grievance (complaint) on behalf of the member by:

1. Contacting any CHS-LA staff member at 855-CHS-LA4U or 855-247-5248.
2. Contacting the Utilization Management Department (for grievance related to denial or reduction in prescribed treatment) at 855-PRE-AUTH or 855-773-2884.
3. Faxing a letter to 866-907-4842.
4. Sending a letter to:  
Grievance System Coordinator  
CHS-LA, Quality Department  
1000 118th Ave North  
St. Petersburg FL, 33716

Our goal is to resolve all grievances promptly. Upon receipt of a telephonic grievance, staff will make every effort to resolve the issue during the call. If resolution is not achieved during the call, CHS-LA will send written notification of the resolution within thirty (30) days of initial receipt of grievance. If additional information is necessary to make a determination, an extension of fourteen (14) days given with members approval.

If the member is not satisfied with the resolution, an appeal may be submitted either telephonically or in writing directly to the Grievance System Coordinator (GSC). The GSC will conduct a complete review of information, request any additional information necessary to make a determination and render a resolution decision, in writing, within thirty (30) calendar days of receipt of the appeal. Written notification will include process for accessing DHH State Fair Hearing.

### **State Fair Hearing**

After exhausting CHS-LA appeal process, the member, or provider on behalf of the member, may request a State Fair Hearing. This request must be completed, either orally or in writing, within thirty (30) days of the determination.

CHS-LA will provide assistance to the member, or authorized representative, in preparing and filing for the State Fair Hearing in accordance with organizational policies and at no charge to the member or authorized representative.

The primary goal in a State Fair Hearing is to assure that the policy applicable to the situation is correctly applied. For this reason, the CCN must assist the member or authorized representative in filing and preparing his/her State Fair Hearing request and help prepare the case for appeal, if necessary. The State Fair Hearing process also provides a feedback mechanism whereby DHH policy-making officials can determine if modifications to policies and procedures are needed.

## Provider Complaint Procedure

Outside of a formal appeal of an adverse determination, there is no limitation placed upon Providers for when they may submit concerns/complaints to CHS-LA.

Providers should submit concerns/complaints related to support and services provided to them by CHS-LA to CHS-LA as well as concerns/complaints regarding CHS-LA Members. All concerns that are peer related will be managed in accordance with Federal Peer Review standards in or to provide said review in a protected environment. Any complaint or concern that has member specific PHI as a component will be managed in accordance with HIPAA privacy and security regulations. Any concerns/complaints directly related to DHH policy and procedures should be directed to DHH. Any concern/complaint made to CHS-LA that involves DHH policy and procedures will be referred by CHS-LA's Executive Director to our designated DHH staff liaison within one (1) business day of receipt. Response to providers in this instance will indicate that the concern has been referred to DHH for resolution.

Providers may submit concerns/complaints on a case by case basis or may report a trend they have noticed, citing multiple similar incidents that have occurred over a period of time. Providers may submit concerns/complaints telephonically, in writing, or in person through several avenues including:

- Provider Services Representative- Each provider has a designated on-site Provider Services Representative who is available, via cell phone and email, from 8:00 a.m. to 5:00 p.m. Central Time for non-emergent issues, but will be available at all times if a matter is urgent.
- Provider Call Center Representatives- Each provider has a designated Call Center representative during their regular hours (staff will work on staggered schedules) and access to all Provider Call Center staff between 7:00 a.m. to 7:00 p.m. Central Time. Providers will have the option of leaving a message with the Provider Call Center outside of business hours. All messages will be responded to within one (1) business day.
- Executive Director- Providers may request to speak or meet directly with the Executive Director through any of the mechanisms mentioned above. Every effort will be made to accommodate this request within three (3) business days. If the Executive Director is not available during that timeframe, the Provider shall be notified of this within one (1) business day of request and an appointment shall be set for the earliest possible time.
- Medical Directors- Providers may request to speak or meet directly with the Medical Directors through any of the mechanisms mentioned above. Every effort will be made to accommodate this request within three (3) business days. If neither of the Medical Directors is available during that timeframe, the Provider shall be notified of this within one (1) business day of request and an appointment shall be set for the earliest possible time. Should the provider require immediate access to a Medical Director the request will be escalated to the President and Chief Medical officer for an Expedited Notification. This will be utilized in the absence of the immediate availability of a Medical Director in a situation that could compromise access and availability of necessary care for a Member or if there is a quality of care concern and the Member's clinical status is in jeopardy.
- Provider website- Providers may contact CHS-LA via the CHS-LA website. Any inquiry, complaint, or request submitted via the website shall be responded to within one (1) business day.

Capturing, tracking, and reporting on status of provider complaints, inquiries, and requests shall include the following processes:

- Each provider concern/complaint is logged into a Provider Concern Log.
- Consistent with CHS-LA's focus on customer satisfaction, every effort is made to resolve the concern/complaint at the time it is received. However, CHS-LA shall gather information from all pertinent sources, to include staff, Members, other Providers, or state officials prior to resolution.
- If assistance or resolution cannot be reached at the time of the initial call, response from Provider Services staff to the provider is required within one (1) business day. This response will, at a minimum, provide a status report of the investigation of the complaint.
- Whenever possible, final resolution/response to concern/complaint will be provided within three (3) business days, both verbally and in writing.
- All responses, including interim responses, will be logged in the Provider Concern Log.
- The designated Provider Services Representative shall typically respond to the Provider raising the concern/complaint. However, any concern/complaint that is deemed serious or could result in a threat to network adequacy will trigger an automatic referral to the CHS-LA's Executive Director and Medical Director(s). The Executive Director and, if appropriate, a Medical Director will join the Provider Services Representative in responding to the provider.
- All inquiries, concerns/complaints and requests will be evaluated on a monthly basis by the Executive Director or, upon hiring, the Provider Claims Educator for identification of trends or improvement opportunities.
- Trends that are identified and actions taken in response to those trends will be reported to the Physician Advisory Committee (PAC) and Quality Management Committee (QMC) on a quarterly basis.

## **Process to Request Reassignment of Members from Practice**

Community Health Solutions of Louisiana (CHS-LA) will take the following steps to reassign members to network providers, in the event that a PCP has requested a member be assigned elsewhere:

- The assigned PCP must send a letter, which has been reviewed and approved by DHH, to the member with a copy to CHS-LA giving at least a thirty (30) day notice that the PCP will no longer serve as the member's PCP. The letter will stipulate that the member will be served by the current PCP through the end of the following month after the thirty (30) day notice and that the member should contact CHS-LA for assistance with selection of a new PCP.
- Upon receipt of the PCP notification letter, a CHS-LA Member Services Representative will attempt to contact the member within one (1) business day to facilitate transfer of member to an alternate PCP within CHS-LA's network and the member's geographic area. At least three telephonic attempts will be made and documented. If the Member Services Representative is unsuccessful in making telephone contact, then written notification will be sent informing the member of assignment to a new PCP and the effective date of the reassignment.
- To ensure continuity of care and provision of medically necessary healthcare services, CHS-LA will coordinate with the original PCP to ensure that this provider/practice forwards all patient records to the new PCP.
- CHS-LA tracks all PCP requests and rationale for reassignment on a quarterly basis to determine if there are trends that require attention. Should a PCP have an inordinate number of requests for transfer, a referral will be made to CHS-LA's Medical Directors for intervention with the PCP and possible request for Corrective Action via the Quality Management Committee.

PCP requested disenrollment data will be included in the Physician Dashboard to allow providers to track their own results compared to their peers.

## Care Management Program

Community Health Solutions of Louisiana's (CHS-LA) approach to Care Management is an integrated delivery model that provides a patient-centric system of care directed by the PCP. Through a collaborative process that involves Members, family members, authorized representatives, PCP, and CHS-LA's Care Management Registered Nurses (RNs), our Care Management program promotes preventive services, educates Members, provides early risk identification, assesses, plans, implements, coordinates, monitors and evaluates the individual on-going care needs of the Member.

The characteristics of the targeted members for CHS-LA's Care Management services include, but are not limited to:

- Chronic, complex conditions
- Disabilities
- On-going health service needs
- Lifestyle / risk behaviors
- Sentinel events
- Maternity
- Birth through toddler (EPSDT and immunization)

Other defined utilization indicators including:

- Recidivism (Emergency Room/Inpatient)
- Pharmacy utilization (drug seeking behaviors / "doctor shopping")

Members are identified through various sources including:

- Risk stratified diagnosis specific claims data housed in the CHS-LA's data warehouse
- Welcome calls
- Self-referral
- Health Risk Assessment (HRA)
- Inpatient and outpatient utilization, pharmacy utilization or quality management data
- Service authorization and specialty referral data
- PCP / health care provider referrals

Members are encouraged to participate in Care Management through the use of Motivational Interviewing. The Care Management RNs have been trained in motivational interviewing techniques to improve Member participation. Specifically, these techniques are:

- Assessment of motivation to change
- Facilitation of "change talk". "Change talk" tends to be associated with successful outcomes. This strategy elicits reasons for changing from the Member.
- Facilitation of ownership of change. This allows Members to give voice to what they would need to do to change and establish personal goals.
- Open-ended questions
- Reflective listening

- Normalizing
- Decisional balancing

Assessment of Member needs is achieved through a combination of screening tools. While participation in Care Management programs is a matter of Member choice, all Members identified as possibly benefiting from Care Management are encouraged to complete an HRA. Based on HRA results, a Disease Specific Assessment (DSA) may be performed. Based upon information gathered through these assessments, Care Management RNs utilize evidence-based care guidelines to establish a patient-centric Care Plan.

CHS-LA Care Plans are developed through active involvement on the part of our Members and individuals they view as important to their health status. CHS-LA sees this involvement as an essential component of effective Care Plan development as it provides Members ownership of the process. HRA, DSA and Care Plans are communicated with the treating PCP for review, modification or recommendation.

Care Management RNs will specifically address medication reconciliation issues, if identified during assessment, to ensure PCP is aware of all medications prescribed for the Member. Based on PCP feedback regarding the Care Plan, interventions and goals may be re-established or additional problems identified. Care Management RNs will incorporate PCP feedback into the Care Plan and initiate interventions.

To ensure coordination between CHS-LA's Care Management and Disease Management programs and to prevent confusion or intrusion into the PCP/ Member / responsible party relationship, CHS-LA has a dedicated RN who manages both of these programs for specific Members. CHS-LA's patient-centric software system, Consensus, supports the RN in managing this dual role. Additionally, CHS-LA has organized practice specific teams that are composed of an RN, a Louisiana-based Provider Representative, and a telephonic Provider Representative. We did so to facilitate coordinated communication between our PCP practices and CHS-LA.

Care Management RNs evaluate progress toward goals during on-going communication with the Member, family members and health care team. When indicated, interventions and goals are re-evaluated to best meet the needs of the Member. Any adjustments to the Care Plan are communicated with the PCP to ensure that the PCP has an opportunity to review, modify or recommend changes in clinical management.

CHS-LA can assist PCPs in accessing specialty care services through the development of Memoranda of Understanding with healthcare systems that provide these services. While referral authorizations are provided by the PCP, it is the role of the Care Management RN to facilitate referrals and Member compliance with specialty care services. Additionally, CHS-LA has a Physician Communication Form that is utilized between the PCP and specialty physician at the time of referral to ensure that communication is a synopsis of the clinical issues and provides an opportunity for the specialist to communicate his or her findings or recommendations for on-going clinical management. This referral is faxed between providers via a HIPAA secure communication device. All specialty referrals, with resulting goals and outcomes, are incorporated into the Care Plan.

PCP input in Care Plan development and interventions is sought throughout our involvement with our Members. The PCP is given a comprehensive packet to assist in recommendations for clinical and psychosocial management and support for the Member. On-going communication occurs with the PCP when there are changes in Members' clinical status or non-compliance with the Care Plan.

## Care Plan Development

Care Plans are developed for a subset of Community Health Solutions of Louisiana's (CHS-LA) Members. These Care Plans are developed by CHS-LA's Registered Nurse Care Managers through analysis of historical claims data, the provision of Health Risk Assessments (HRA) and Disease Specific Assessment (DSA), and input from the Member and the Member's PCP. The goal of the Care Plan is to promote prevention activities, facilitate self-management on the part of the Member or Member's significant others, ensure appropriate screenings are carried out and medically necessary referrals are made by PCP, and to measure functional outcomes.

Member identification is made through:

- PCP referrals
- Self-Referrals
- Member Services referrals
- 24 hour nurse line referrals
- Claims queue
  - Asthma
  - Emergency Room (ER) utilization
  - High cost
  - Maternity
  - Readmissions

Upon identification as a candidate for Care Management, the Member is contacted by either a CHS-LA Care Advocate or CHS-LA RN Care Manager and is asked to complete a Health Risk assessment (HRA). All aspects of Care Management are voluntary.

Upon completion of the HRA and any Disease Specific Assessments (DSA) triggered through the HRA, the Member is assigned an acuity level. The acuity levels are:

- AL1-acute episode, no chronic or complex conditions
- AL2-acute episode, chronic or complex condition, stable
- AL2M-acute episode, chronic or complex condition, at risk for exacerbation
- AL3-acute episode, chronic or complex condition unstable
- AL4-acute episode, catastrophic condition

For Members with an Acuity Level of 3 or 4, an RN is assigned to develop an individualized Care Plan in collaboration with the Member, member's family or significant others and the PCP.

In the development of the Care Plan, the following factors are considered:

- The disease knowledge of the member and/member's family/responsible party
- Primary diagnosis and all co-morbidities including behavioral health and psychosocial conditions
- Medical Record information from primary care/specialist visits
- Identified psycho-social problems/needs
- The availability of and need for community resources such as:
  - State and Federal Assistance Programs
  - SNAP

- Civic and Religious Groups
- Specific Advocacy Groups
- Assisted Living and/or Home Health Support Services
- Day Programs
- Behavioral Health Services
- Public Health Department Services
- Medical transportation programs

The Care Plan is individualized for the Member and will:

- Establish interventions
- Address needs regarding scheduling assistance
- Establish short term and long term goals for interventions
- Establish target dates for short term and long term goals
- Establish expected outcomes

After initial development by the RN Care Manager, the Care Plan is submitted to the PCP for revision/approval. If there is no response from the provider within 7 days, the care plan will be implemented as written.

Upon PCP approval, the Care Plan is implemented and monitored by the RN Care Manager through direct telephonic and/or face-to-face contact with the Member and analysis of claims data.

The benefits for PCP's of referring/encouraging Members to participate in the Care Management program are:

- The RN will interact regularly with the member to facilitate timely interventions, support member compliance with the physician's expectations and, as indicated, monitor progress toward the Care Plan's goals and outcomes.
- Depending on the member's educational needs, the RN will conduct extensive disease specific education in order to increase the member's knowledge base in the self-management of their medical condition(s).
- The RN can assist the PCP in overseeing and addressing issues such as fragmented, multi-physician utilization patterns.
- The RN can easily detect adverse utilization patterns regarding inappropriate medication refills, failure to utilize establish medical home, failure to follow up for scheduled preventive services and frequent use of Emergency Room services.
- The RN can play a crucial role in proactively managing and positively impacting member behavior and care.
- The RN can provide scheduling assistance, if needed, for both physical and behavioral health services.

Evaluation and revision of the Care Plan is conducted on an on-going basis based on:

- The member's needs.
- The physician's recommendations.
- The frequency of follow up appointments.
- A change in treatment and frequency of diagnostic testing.

Care Plans will be reviewed, at minimum, on an annual basis.

Cases will be closed, and the PCP notified of closure, when:

- Member meets outlined goals and acuity level is decreased.
- Member states they no longer want to participate in Care Management.
- Member transfers to an institutional setting.
- Member cannot be reached.

## **Disease Management Education Program Wellness/Prevention Program**

Community Health Solutions of Louisiana (CHS-LA) offers two major types of member education- Disease Management Education and Wellness/Prevention programs.

Disease Management programs include:

- Cardiovascular disease (includes hyperlipidemia and obesity management)
  - Hypertension, as applicable to disease process (CAD, CHF, Diabetes)
  - Coronary Artery Disease
  - Congestive Heart Failure
- Pulmonary disease
  - Asthma
  - Chronic Obstructive Pulmonary Disease (restrictive airway disease)
- Endocrine (includes hyperlipidemia and obesity management)
  - Diabetes, Type I and Type II (adult and pediatric)
- Hematological
  - Sickle cell anemia

Wellness / Prevention programs include:

- Maternity / high risk maternity education and management program (includes Family Planning and WIC Program referrals)
- Infant / toddler growth and development program (includes EPSDT and immunizations)

The goal of our Disease Management Program is to facilitate our members' receipt of necessary and appropriate care while ensuring access to primary care PCPs. This is accomplished through a collaborative process with PCPs which:

- Promotes preventative services;
- Educates members;
- Provides early identification of risk; and
- Assesses, plans, implements, coordinates, monitors and evaluates the individual care needs of the Member.

Our program focuses on members with one or more chronic illnesses and includes an assessment of motivation to change and the use of motivational interviewing. Through the use of evidence-based guidelines, risk stratification methodology, and assessment tools, CHS-LA will define members' needs and provide resource coordination, education and advocacy.

To identify members with chronic and/or complex conditions or wellness/prevention opportunities for education and management, CHS-LA utilizes the following data sources:

- Claims data
- Information obtained from the twenty-four (24) hours, seven (7) days a week nurse triage line
- Utilization management data
- PCP referral
- Member self-referral

Claims specific diagnostic triggers generate referrals into disease/health specific nursing queues for triage, risk stratification, Health Risk Assessments (HRA), and Disease Specific Assessments (DSA).

Utilizing Consensus, CHS-LA's proprietary, patient-centric software, these comprehensive assessments include risk identification through review and assessment of:

- Medical / family history
- Disease conditions
- Psycho-social status /risk indicators
- Functional status /safety issues
- Economic factors
- Nutrition and exercise

These assessments are performed by Care Manager/Disease Educator Registered Nurses (RNs).

Through collaboration with the Member, their support system, the assigned PCP and other health care team members, an individualized plan of care and education is developed. Patient- centered Care Plans and educational sessions, along with educational tools and coaching strategies, are implemented by the RN to help members:

- Improve self-management.
- Change health behaviors.
- Prevent exacerbations and /or complications of health conditions.
- Improve clinical/ functional outcomes.
- Decrease acute care and ER recidivism, resulting in appropriate utilization of health care resources and decrease in cost associated with the chronic, complex condition.

PCPs participate in care coordination efforts and disease management education through collaboration with the assigned RN Case Manager. PCPs are encouraged to refer all members who would benefit from Case Management services directly to the Care Management department at 855-CHS-LA4U or 855-247-5248.

## NCQA PCMH Overview and Support

Community Health Solutions of Louisiana (CHS-LA) recognizes the importance of the goals associated with NCQA's Patient-Centered Medical Home (PCMH) criteria: organizing care around Members' individual needs and preferences; working collaboratively with other healthcare and social services providers to address Members' needs in a holistic manner; and coordinating and tracking care over time to improve clinical outcomes. As required in Section 6.9 of the RFP, CHS-LA will support our PCPs in achieving NCQA (PCMH) recognition status through a number of mechanisms. Specific activities CHS-LA will engage in that support this are:

- Participation in Patient-Centered Primary Care Collaborative activities.
- Provision of educational programs on the PCMH model in general and on the Plan, Do, Study, Act (PDSA) Quality Improvement cycle specifically. These educational programs will be provided through collaboration with provider associations and through CHS-LA hosted webinars. Additionally we will provide links, on our CHS-LA website, to NCQA PCMH materials.
- Provision of PCPs with monthly, quarterly and annual performance data to assist them in evaluating their patient population, including data related to access. Performance data will be provided in comparison to national benchmarks and their peer group.
- Assistance to PCPs, when requested or when provider performance indicates a need, in identifying appropriate and meaningful Quality Improvement projects to improve care delivery to their patient population.
- Assistance to PCPs in adopting recognized Health Risk Assessments (HRA), Disease Specific assessments (DSA), patient-centered Care Plan development, and disease management education protocols.
- Facilitation of access to specialty services for our Members, when appropriate.
- Facilitation of data exchange with other providers such as specialists and labs through encouragement of PCPs to participate in government sponsored Health Information Technology (HIT) incentive programs and provision of links to state and federal resources that support these programs.

**For our shared patients/Members**, provision of our Care Management services will assist PCPs in meeting specific standards such as:

- **PCMH1: Enhance Access and Continuity**
  - Through the enrollment process, Members have the opportunity to select their physician, supporting access to care.
  - CHS-LA will assist PCPs in meeting this element through the provision of a twenty-four (24) hour nurse line that is available to all our Members and through the documentation and sharing of this advice with our network PCPs. Access to the 24/7 Clinical Nurse Line provides Members with access to culturally and linguistically appropriate clinical advice during and after normal office hours.

- **PCMH2 Identify/ Manage Patient Populations.**
  - CHS-LA will assist PCPs in meeting this element by carrying out comprehensive Health Risk Assessments (HRA) and Disease Specific Assessments (DSA) on Members for whom a referral has been made to Care Management and/or for whom claims data has established high risk flags. Because we support a collaborative, patient centered, team approach to care, results of the HRA and DSA and pro-active point of care reminders are communicated by CHS-LA to the PCP.
  - CHS-LA will provide blaster calls in the areas of wellness and prevention to include, at a minimum, EPSDT well-child visits, immunizations (adult and child), women’s health screenings, and disease specific quality indicators.
  - For patient populations with recidivistic activity in ER and inpatient utilization, CHS-LA will provide the PCP with Physician Dashboard information on Member specifics to allow for PCP focused management.
  - CHS-LA will provide PCPs with Member specific pharmaceutical/ provider utilization data to allow for PCP focused management.
  
- **PCMH3 Plan and Manage Care:**
  - **3A Implement Evidence-based guidelines-** CHS-LA will assist PCPs in meeting this element through the use of Milliman CareGuidelines (15th edition) during the establishment of Care Plans. These patient-centered Care Plans are provided to the PCP who is responsible for revising and implementing these Care Plans in his/her provision of care to the Member.
  - **3B Identify High-Risk Patients-** CHS-LA will assist PCPs in meeting this element through the identification of high-risk Members. When provided historical claims data, CHS-LA will identify high-risk Members upon enrollment in the CCN-S. CHS-LA will continue to identify high-risk Members after enrollment based upon diagnoses, service utilization, recidivism, prescriptions, and medication compliance. These Members are targeted for Care Management intervention coordinated with the PCP. Additional risk issues related to health behavior, mental health, substance abuse or functional limitations are evaluated as part of the HRA/DSA.
  - **3C Care Management-** CHS-LA will assist PCPs in meeting this element through the provision of patient-centered Care Plans and Intensive Care Management support. Care Plan interventions and goals are established based upon information gathered through HRAs and DSAs. Through collaboration between the Member, PCP, and care coordinator, progress toward goals and/or barriers to progress are identified and addressed.
  - **3D Manage Medications-** CHS-LA will assist PCPs in meeting this element through the CHS-LA’s Care Management program which includes evaluation of medications and identification of need for medication reconciliation, which is communicated to PCP.

- **PCMH4 Provide Self-Care Support and Community Resources**
  - **4A Support Self-Care Process-** CHS-LA will assist PCPs in meeting this element through the provision of Chronic Care/Disease Management and Prevention/Wellness Education to our Members with:
    - **Asthma**
    - **Chronic Obstructive Pulmonary Disease**
    - **Congestive Heart Failure**
    - **Coronary Artery Disease**
    - **Hypertension when related to disease process**
    - **Diabetes**
    - **Sickle Cell Disease**
    - **Maternity**
    - **Infant/Toddler (Birth to 36 months) Growth and Development**
  - **4B Provide Referrals to Community Resources-** CHS-LA will assist PCPs in meeting this element through the development of community-based resource guides that will be posted on our CHS-LA website and incorporated in Consensus, our Care Management software system. Community resource needs are also identified in patient-centered Care Plan.
  
- **PCMH5 Track and Coordinate Care**
  - **5A Referral Tracking and Follow-Up-** CHS-LA will assist PCPs in meeting this element through the provision of monthly Dashboard of all services provided to their Members, and billed through Medicaid. This will allow PCPs to determine if their patients were seen for their follow-up appointments and to provide patient-focused management.
  - **5B Coordinate with Facilities/Care Transitions-** CHS-LA will assist PCPs in meeting this element through the provision of intensive Care Management upon discharge from a hospital. Prior to discharge from an Acute Care Facility, the Utilization Management (UM) nurse will begin work with the hospital discharge planner to determine if a Member will require intensive Care Management on discharge. If so, the UM nurse will refer the Member to our Care Management staff to begin preparation for transition from the acute care setting. CHS-LA Care Management staff will communicate with the PCP throughout this process to ensure complete understanding of the PCPs plans for clinical management.
  
- **PCMH6 Measure and Improve Performance**
  - **6A Measure Performance-** CHS-LA will assist PCPs in meeting this element through the provision of a monthly Physician Dashboard to PCPs which provide data regarding their performance on key performance measures and provide local and national benchmark data. Consistent communication between CHS-LA and PCPs will focus on use of clinical performance data for continuous quality improvement for vulnerable populations with a goal of demonstrating sustained improvement in accordance with best practice standards (Milliman CareGuidelines (15th edition)).
  - **6B Measure Patient/Family Experience-** CHS-LA will assist PCPs in meeting this element through inclusions of CAHPS data and results of Care Management satisfaction surveys in the monthly Physician Dashboard.

- **6C Implement Continuous Quality Improvement-** CHS-LA will assist PCPs in meeting this element through provision of performance data, assistance in identifying appropriate quality improvement projects, and training on implementing a quality improvement process.

CHS-LA will submit to DHH an annual report of all network PCPs who have achieved NCQA PCMH recognition. This report shall include the level of recognition achieved and will provide aggregate data that relates to the State's thresholds for PCMH recognition among our network PCPs. CHS-LA will be tracking this internally to identify barriers to and strategies for meeting the State's requirements. PCMH status will be a standing agenda item for our Physician Advisory Committee (PAC) and Quality Management Committee (QMC).

## Document Distribution System

To assist our network providers with management of their patients' care, Community Health Solutions of Louisiana (CHS-LA) provides a number of monthly reports to CHS-LA enrolled practices. These reports are available through our Document Distribution System (DDS). Providers can access DDS through CHS-LA's website or can request assistance from their Provider Representative or our Helpdesk at 1-888-366-6243, extension 3652. Providers must sign the DDS User Agreement.

The reports available through DDS are:

1. Member List– A list of all membership activities including addition of new members, continuation of existing members and disenrollments.
2. Redeterminations– A list of members who are assigned to the medical home that are approaching their Medicaid review/renewal date.
3. COB/Other Insurance– A list of all members in the medical home who have other insurance.
4. Lab & X-Ray Claims Activity– A list of paid claims, by date of service, for lab and x-ray services performed for a member assigned to the medical home.
5. Pharmacy Claims Activity– A list of paid claims, by date of service, for pharmacy services performed for a member assigned to the medical home.
6. Medical Home Claims Activity– A list of paid claims, by date of service, for services performed by the medical home or a practitioner who practices in that medical home for a enrolled member.
7. Referred Claims Activity– A list of paid claims, by date of service, for services with a referral number performed for a member assigned to the medical home.
8. Non-referred Claims Activity– A list of paid claims, by date of service, for services without a referral number performed for a member assigned to the medical home.
9. Hospitalizations– A list of hospitalizations for members of the medical home.
10. Re-admissions– A list of re-admissions, defined as an admit date within thirty (30) days of prior discharge date, for members of the medical home.
11. ER Utilization– A list of paid services performed in the ER for members of the medical home.

It is CHS-LA's intent that providers will review these reports and/or request addition reports to most effectively manage their patients care.

## Physician Dashboard

Community Health Solutions of Louisiana (CHS-LA) understands the importance of providing physicians with information to help track and measure performance for patient care. Therefore, CHS-LA will provide a Physician Dashboard including reports on your patient specific data so that you can easily identify strengths and opportunities for improvement. Our clinical, quality, and provider relations staff will meet with you to review your patient membership data. Through partnership and collaboration, we look forward to improving the health of our Louisiana Medicaid members.

CHS-LA's Physician Dashboard will include monthly, evidenced-based utilization and quality measures with quarterly aggregates. The measures will address overall performance as well as specific disease processes applicable to the population served. The targeted diseases include:

- Coronary Artery Disease
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Asthma
- Diabetes

Utilization data will provide information regarding:

- Number of Emergency Room Visits
- Hospital admissions
- Readmissions within 15 days and 16 to 30 days with the same principal diagnosis as the admission
- An average length of the hospital stay

Preventive health measures for the pediatric population include Health Effectiveness Data and Information Set (HEDIS) and the Children's Health Insurance Program Reauthorization Act (CHIPRA) measures plus a CAHPS Pediatric Satisfaction Survey. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) reporting will also be included.

Adult HEDIS Quality Measures address preventive health screenings and measures to assist in the management of chronic diseases such as breast cancer screening, cervical cancer screening, colonoscopy, HgbA1c, and lipid profile. Satisfaction surveys are also included.

Maternity measures are based on HEDIS / CHIPRA Quality Measures and address prenatal and post-partum care, birth weights, and tobacco use during pregnancy.

The Physician Dashboard also addresses complaints / concerns from the Members regarding the physician and / or office staff. This section is broken down by type of complaint and resolution.

The CHS-LA Physician Dashboard is based on the latest evidenced based literature and will be revised as necessary when new or more favorable treatment modalities become available. Updates will be announced in the monthly CHS-LA provider newsletter.

## **Per Member, Per Month Coordination Fee**

Community Health Solutions of Louisiana (CHS-LA) will pay its PCP network providers a base Per Member, Per Month (PMPM) Coordination Fee of \$1.50 as established by DHH. For SSI members, CHS-LA will add an additional \$.50, bringing the base PMPM to \$2.00. In addition, CHS-LA will augment the base Coordination Fee as follows:

- Extended Hours- Access and Availability           \$.25 PMPM
- Urgent Care- Access and Availability               \$.25 PMPM
- 500-999 Members- Access                             \$.50 PMPM
- 1000+ Members- Access                             \$1.00 PMPM

Extended Hours is defined by DHH as office hours after 5:00 PM for at least two hours at least one day a week and/or office hours for at least four hours on Saturday. CHS-LA will offer the extended hour bonus for a minimum of six (6) hours offered outside the hours of 8:00 a.m. through 5:00 p.m. Monday through Friday.

Urgent Care is defined as availability of same day appointments for conditions that are likely to deteriorate into an emergent condition, cause the development of a chronic illness or need for more complex treatment.

## **Shared Savings Calculation**

Direction regarding Shared Savings calculations will be finalized once DHH has CMS approval regarding performance measures. Upon determination of those measures, CHS-LA will distribute 50% of Shared Savings disbursement to its network providers based on their performance on the same measures. Distribution to providers will occur within thirty (30) calendar days of CHS-LA's receipt of funds from DHH.

## **Forms and Reference Documents**

**VERY IMPORTANT, PLEASE READ CAREFULLY: System Usage Agreement**

Practice Name		Practice ID	
Users authorized by this practice to access the CHS Document Distribution System:			
Name	Location	Email Address	Password

The CHS Document Distribution System contains Protected Health Information (PHI) as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Community Health Solutions of America, LLC (CHS) provides this data under the allowances for communication of PHI for the purposes of treatment, payment or operations. CHS has taken steps to secure its systems generally and the CHS Document Distribution System specifically in accordance with HIPAA regulations. Please initial that you acknowledge each statement:

- \_\_\_ 1. This medical practice has requested that the individuals listed above be given access to the CHS Document Distribution System. These individuals are designated by this practice as having reasonable need to view PHI as required by their job function and that the medical practice will ensure that such personnel be given the least access to PHI necessary to perform their tasks.
- \_\_\_ 2. This practice affirms that all the above listed employees have received training in HIPAA regulations and in the protection of confidential information.
- \_\_\_ 3. If at any point any of the above staff members leave the practice through voluntary or involuntary termination of their employment, or change roles to a position no longer requiring access to this information, this practice will notify CHS **IMMEDIATELY** at [edi@chsamerica.com](mailto:edi@chsamerica.com) for termination of the employee’s username and password. If, for any reason, your electronic transmission (email) returns your message as undeliverable, or if there is any other failure in electronic transmission, please print or otherwise convert your electronic transmission into written form and fax it to CHS HIPAA Privacy Official at 727-498-3036. In your written document, please detail the nature of the problem that occurred in the electronic/email transmission, along with a printout or other documentation that show your inability to successfully transmit your message.
- \_\_\_ 4. Should this practice become aware of a violation of a CHS Louisiana member’s privacy, inappropriate access to the CHS Document Distribution System, or an illegal disclosure of PHI, this practice will notify the CHS HIPAA Privacy Official **IMMEDIATELY** at 727-498-0036. If, for any reason, you are not able to personally speak with a CHS HIPAA Privacy Official, then notify us by electronic transmission and facsimile to 727-498-3036, detailing every potential access violation or other potential improper conduct, including specific names and any documentary evidence that would support such conduct.

As an authorized representative of \_\_\_\_\_  
Practice Number                      Practice Name

I hereby affirm and acknowledge that this practice takes **sole responsibility** for any disclosures of protected health information resulting from the inappropriate use of the CHS Document Distribution System.

\_\_\_\_\_  
Printed Name    Signature    Date

\_\_\_\_\_  
CHS Representative    Signature    Date

# Provider Data Form – For Credentialing Purposes



To begin your credentialing process, please use this simple, standardized form. **Please note that the top portion of this form is required information.**

-----

DATE:			
Last Name:	First Name:	Middle Initial:	
Date of Birth:	Primary Telephone No.:		
Primary Office Street Address:			Suite #:
Primary Office City:	State:	County:	Zip:
Provider Type (MD, DO, DC, DDS, DMD, DPM, etc) :			
Specialty:	Applying As: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Allied Health Professional		
Are you board certified? Yes No	If Yes, board name:		
Are you registered with CAQH? Yes No	If Yes, CAQH Provider ID:		

-----

If you are **not** registered with CAQH, please provide the following additional information, which is necessary to register you with the CAQH Universal Provider DataSource.

Primary Fax No.:	Email Address:
Social Security No.:	DEA Certificate No.:
State License No.:	Licensed State:
UPIN:	Tax ID:

**Note:** If you have already completed your application with CAQH, please ensure that you have authorized CHS-LA to access your data



# LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

## DIRECTIONS

Please type or print in black ink when completing this form. If you need more space or have more than four locations, attach additional sheets and reference the question being answered. Please see page 9 for a list of required documents.

**\*\* All sections must be completed in their entirety. "See C.V.", not acceptable\*\***

## GENERAL INFORMATION

LAST NAME		SUFFIX	FIRST	MIDDLE	GENDER <input type="radio"/> MALE <input type="radio"/> FEMALE	
DEGREE: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> DC <input type="checkbox"/> DDS <input type="checkbox"/> DMD <input type="checkbox"/> OTHER _____						
Any other name under which you have been known? (AKA) LIST			ECFMG NUMBER		UPIN NUMBER	
HOME STREET ADDRESS			CITY		STATE	ZIP CODE
HOME PHONE NUMBER		PAGER NUMBER/ANSWERING SERVICE		HOME E-MAIL ADDRESS (Optional)		
SOCIAL SECURITY NUMBER		DATE OF BIRTH	BIRTH PLACE (CITY, STATE)		RACE/ETHNICITY (Voluntary)	
NPI - INDIVIDUAL		NPI - GROUP		MEDICAID PROVIDER NUMBER		MEDICARE PROVIDER NUMBER

## PRIMARY PRACTICE LOCATION

INSTITUTION/GROUP/CLINIC NAME (If applicable)				OFFICE MANAGER			
STREET ADDRESS			CITY		STATE	ZIP CODE	
PHONE NUMBER		FAX NUMBER		OFFICE E-MAIL			
TYPE OF PRACTICE: <input type="checkbox"/> SOLO <input type="checkbox"/> MULTISPECIALTY GROUP <input type="checkbox"/> SINGLE SPECIALTY GROUP <input type="checkbox"/> HOSPITAL-BASED							
TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER				TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION			
Name to which Employer Identification Number (EIN) is registered with the IRS (Important: must match IRS information exactly)							
BILLING ADDRESS (Address to which you want payments sent)				CONTACT PERSON		TELEPHONE NUMBER	
CITY		STATE		ZIP CODE		BILLING E-MAIL	
FAX NUMBER							
OFFICE HOURS	MON	TUES	WED	THUR	FRI	SAT	SUN
Do you practice at this location: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Specify)							
Languages spoken at this location: (other than English)							<input type="checkbox"/> Provider <input type="checkbox"/> Other
Accepting Patients?		<input type="checkbox"/> New <input type="checkbox"/> Existing Only		<input type="checkbox"/> Only family members of existing patients <input type="checkbox"/> Other (Specify)			
Age group(s) treated:		<input type="checkbox"/> 0-6 years <input type="checkbox"/> Over 65		<input type="checkbox"/> 7-11 years <input type="checkbox"/> All Ages		<input type="checkbox"/> 12-18 years <input type="checkbox"/> 19-65 years <input type="checkbox"/> Other (Specify):	
Are PAs and/or nurse/paraprofessional practitioners used? <input type="radio"/> Yes <input type="radio"/> No				Is this facility handicapped accessible? <input type="radio"/> Yes <input type="radio"/> No			
Emergency After Hours Number			Arrangements for 24 hour / 7 day a week coverage (Specify)				

Group or Covering Physicians:

**SECOND PRACTICE LOCATION**

INSTITUTION/GROUP/CLINIC NAME (If applicable)						OFFICE MANAGER	
STREET ADDRESS				CITY		STATE	ZIP CODE
PHONE NUMBER		FAX NUMBER		OFFICE E-MAIL			
TYPE OF PRACTICE: <input type="checkbox"/> SOLO <input type="checkbox"/> MULTISPECIALTY GROUP <input type="checkbox"/> SINGLE SPECIALTY GROUP <input type="checkbox"/> HOSPITAL-BASED							
TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER				TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION			
Name to which tax ID number is registered with the IRS (Important: must match the name given on IRS information given)							
BILLING ADDRESS (Address to which you want payments sent)				CONTACT PERSON		TELEPHONE NUMBER	
CITY		STATE		ZIP CODE		BILLING E-MAIL	
OFFICE HOURS		MON	TUES	WED	THUR	FRI	SUN
Do you practice at this location: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Specify): _____							
Languages spoken at this location: (other than English) _____							<input type="checkbox"/> Provider <input type="checkbox"/> Other
Accepting Patients?		<input type="checkbox"/> New <input type="checkbox"/> Existing Only		<input type="checkbox"/> Only family members of existing patients <input type="checkbox"/> Other (Specify): _____			
Age group(s) treated:		<input type="checkbox"/> 0-6 years <input type="checkbox"/> Over 65		<input type="checkbox"/> 7-11 years <input type="checkbox"/> All Ages		<input type="checkbox"/> 12-18 years <input type="checkbox"/> 19-65 years <input type="checkbox"/> Other (Specify): _____	
Are PAs and/or nurse/paraprofessional practitioners used? <input type="radio"/> Yes <input type="radio"/> No				Is this facility handicapped Accessible? <input type="radio"/> Yes <input type="radio"/> No			
Emergency After Hours Number			Arrangements for 24 hour / 7 day a week coverage (Specify)				
Group or Covering Physicians:							

**THIRD PRACTICE LOCATION**

INSTITUTION/GROUP/CLINIC NAME (If applicable)						OFFICE MANAGER	
STREET ADDRESS				CITY		STATE	ZIP CODE
PHONE NUMBER		FAX NUMBER		OFFICE E-MAIL			
TYPE OF PRACTICE: <input type="checkbox"/> SOLO <input type="checkbox"/> MULTISPECIALTY GROUP <input type="checkbox"/> SINGLE SPECIALTY GROUP <input type="checkbox"/> HOSPITAL-BASED							
TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER				TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION			
Name to which tax ID number is registered with the IRS (Important: must match the name given on IRS information given)							
BILLING ADDRESS (Address to which you want payments sent)				CONTACT PERSON		TELEPHONE NUMBER	
CITY		STATE		ZIP CODE		BILLING E-MAIL	
OFFICE HOURS		MON	TUES	WED	THUR	FRI	SUN
Do you practice at this location: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Specify): _____							
Languages spoken at this location: (other than English) _____							<input type="checkbox"/> Provider <input type="checkbox"/> Other

### THIRD PRACTICE LOCATION CONTINUED

Accepting Patients?	<input type="checkbox"/> New	<input type="checkbox"/> Only family members of existing patients
	<input type="checkbox"/> Existing Only	<input type="checkbox"/> Other (Specify): _____
Age group(s) treated:	<input type="checkbox"/> 0-6 years	<input type="checkbox"/> 7-11 years
	<input type="checkbox"/> Over 65	<input type="checkbox"/> All Ages
	<input type="checkbox"/> 12-18 years	<input type="checkbox"/> 19-65 years
	<input type="checkbox"/> Other (Specify): _____	
Are PAs and/or nurse/paraprofessional practitioners used?	<input type="radio"/> Yes <input type="radio"/> No	Is this facility handicapped Accessible? <input type="radio"/> Yes <input type="radio"/> No
Emergency After Hours Number	Arrangements for 24 hour / 7 day a week coverage (Specify)	

Group or Covering Physicians:

### FOURTH PRACTICE LOCATION

If you have more than four locations, attach additional sheets with the following information

INSTITUTION/GROUP/CLINIC NAME (If applicable)			OFFICE MANAGER		
STREET ADDRESS		CITY		STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER		OFFICE E-MAIL		
TYPE OF PRACTICE: <input type="checkbox"/> SOLO <input type="checkbox"/> MULTISPECIALTY GROUP <input type="checkbox"/> SINGLE SPECIALTY GROUP <input type="checkbox"/> HOSPITAL-BASED					
TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER			TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION		

Name to which tax ID number is registered with the IRS (Important: must match the name given on IRS information given)

BILLING ADDRESS (Address to which you want payments sent)			CONTACT PERSON		TELEPHONE NUMBER	
CITY	STATE	ZIP CODE	BILLING E-MAIL		FAX NUMBER	
OFFICE HOURS	MON	TUES	WED	THUR	FRI	SUN

Do you practice at this location:  Full-time  Part-time  Other (Specify): \_\_\_\_\_

Languages spoken at this location: (other than English) \_\_\_\_\_  Provider  Other

Accepting Patients?	<input type="checkbox"/> New	<input type="checkbox"/> Only family members of existing patients
	<input type="checkbox"/> Existing Only	<input type="checkbox"/> Other (Specify): _____
Age group(s) treated:	<input type="checkbox"/> 0-6 years	<input type="checkbox"/> 7-11 years
	<input type="checkbox"/> Over 65	<input type="checkbox"/> All Ages
	<input type="checkbox"/> 12-18 years	<input type="checkbox"/> 19-65 years
	<input type="checkbox"/> Other (Specify): _____	
Are PAs and/or nurse/paraprofessional practitioners used?	<input type="radio"/> Yes <input type="radio"/> No	Is this facility handicapped Accessible? <input type="radio"/> Yes <input type="radio"/> No
Emergency After Hours Number	Arrangements for 24 hour / 7 day a week coverage (Specify)	

Group or Covering Physicians:

### CORRESPONDENCE

Please check location where you would like correspondence sent.  
 Primary  Second  Third  Fourth  All  
 Other Address

IF DIFFERENT FROM PRACTICE LOCATIONS:

PHONE NUMBER	FAX NUMBER	E-MAIL
--------------	------------	--------

### MEDICAL RECORDS

Please check location where you would like medical records requests sent.

- Primary   
  Second   
  Third   
  Fourth   
  Correspondence  
 Other address \_\_\_\_\_

If different from practice or correspondence located checked above

PHONE NUMBER

FAX NUMBER

EMAIL

### SPECIALTY

TYPE OF PROVIDER:   
 PRIMARY CARE PHYSICIAN   
 PHYSICIAN SPECIALIST   
 BOTH   
 OTHER SPECIALTY: \_\_\_\_\_

PLEASE LIST PRIMARY AND SUB-SPECIALTIES (as applicable)

BOARD CERTIFIED (ABMS)

Specialty:

Yes  No

Sub-Specialty:

Yes  No

Sub-Specialty:

Yes  No

### BOARD CERTIFICATION

(as recognized by American Board of Medical Specialties)

(Please attach a copy of current certification(s).)

PRIMARY SPECIALTY BOARD (ABMS)	DATE CERTIFIED	DATE RECERTIFIED	STATUS/EXP. DATE
SECONDARY SPECIALTY BOARD (ABMS)	DATE CERTIFIED	DATE RECERTIFIED	STATUS/EXP. DATE
THIRD SPECIALTY BOARD (ABMS)	DATE CERTIFIED	DATE RECERTIFIED	STATUS/EXP. DATE

### DIRECTORY INFORMATION

Check whether the specialty and/or subspecialty(ies) listed above are practiced at each location. Indicate if each specialty is to be noted in the directory. **DISCLAIMER: Use of information may vary by health care organization**

Primary Location	Second Location	Third Location	Fourth Location
<input type="checkbox"/> Specialty	<input type="checkbox"/> Specialty	<input type="checkbox"/> Specialty	<input type="checkbox"/> Specialty
<input type="checkbox"/> Directory	<input type="checkbox"/> Directory	<input type="checkbox"/> Directory	<input type="checkbox"/> Directory
<input type="checkbox"/> Sub-specialty	<input type="checkbox"/> Sub-specialty	<input type="checkbox"/> Sub-specialty	<input type="checkbox"/> Sub-specialty
<input type="checkbox"/> Directory	<input type="checkbox"/> Directory	<input type="checkbox"/> Directory	<input type="checkbox"/> Directory
<input type="checkbox"/> Sub-specialty	<input type="checkbox"/> Sub-specialty	<input type="checkbox"/> Sub-specialty	<input type="checkbox"/> Sub-specialty
<input type="checkbox"/> Directory	<input type="checkbox"/> Directory	<input type="checkbox"/> Directory	<input type="checkbox"/> Directory

IF DIFFERENT FROM PRACTICE LOCATIONS:

PHONE NUMBER

FAX NUMBER

E-MAIL

### PHO / IPA AFFILIATIONS\*

List any other PHO's, IPA's, which you participate in and dates of participation:

\* The intent of this section is to identify any contractual arrangements the physicians have that are in direct conflict with the Plan.

**CURRENT HOSPITAL AFFILIATION**

List the hospital to which you primarily admit your patients: \_\_\_\_\_

List in **chronological** order from oldest to most current all hospitals at which you currently have privileges:

HOSPITAL	LOCATION/ADDRESS	TYPE OF PRIVILEGES	EFFECTIVE DATE MO/YR
----------	------------------	--------------------	----------------------


IF YOU DO NOT HAVE ADMITTING PRIVILEGES, WHO ADMITS FOR YOU AND TO WHAT HOSPITAL? PLEASE LIST PROVIDER'S NAME, SPECIALTY AND HOSPITAL.

--

**EDUCATION**

IF ADDITIONAL TRAINING HAS BEEN COMPLETED, PLEASE ATTACH ON A SEPARATE FORM.

**MEDICAL/PROFESSIONAL SCHOOL:**

CITY	STATE	ZIP
------	-------	-----

DEGREE	YEAR OF GRADUATION	DATES ATTENDED (MO/YR) From                      To
--------	--------------------	--

INTERNSHIP: INSTITUTION NAME	TYPE OF TRAINING
------------------------------	------------------

CITY	STATE
------	-------

UNIVERSITY AFFILIATION	COMPLETED <input type="radio"/> YES <input type="radio"/> NO	DATES ATTENDED (MO/YR) From                      To
------------------------	---	--

RESIDENCY: INSTITUTION NAME	TYPE OF RESIDENCY <input type="checkbox"/> Clinical <input type="checkbox"/> Research
-----------------------------	---

CITY	STATE	DATES ATTENDED (MO/YR) From                      To
------	-------	--

UNIVERSITY AFFILIATION	COMPLETED <input type="radio"/> YES <input type="radio"/> NO
------------------------	---

RESIDENCY: INSTITUTION NAME	TYPE OF RESIDENCY <input type="checkbox"/> Clinical <input type="checkbox"/> Research
-----------------------------	---

CITY	STATE	DATES ATTENDED (MO/YR) From                      To
------	-------	--

UNIVERSITY AFFILIATION	COMPLETED <input type="radio"/> YES <input type="radio"/> NO
------------------------	---

FELLOWSHIP: INSTITUTION NAME	SPECIALTY FIELD	DATES ATTENDED (MO/YR) From                      To
------------------------------	-----------------	--

CITY	STATE	COMPLETED <input type="radio"/> YES <input type="radio"/> NO
------	-------	---

	TYPE OF FELLOWSHIP <input type="checkbox"/> Clinical <input type="checkbox"/> Research
--	--

FELLOWSHIP: INSTITUTION NAME	SUBSPECIALTY FIELDS	DATES ATTENDED (MO/YR) From                      To
------------------------------	---------------------	--

CITY	STATE	COMPLETED <input type="radio"/> YES <input type="radio"/> NO
------	-------	---

	TYPE OF FELLOWSHIP <input type="checkbox"/> Clinical <input type="checkbox"/> Research
--	--

## WORK HISTORY

Using the following codes, please list in **chronological order** from oldest to most current your work history from the time you completed your medical training to the present. **It is very important that you use the month and year for each entity listed.** **Work history is critical. Failure to provide this information may delay your credentialing.**

**CODE:**

**C** = Clinic/Group    **S** = Solo Practice    **A** = Academic (Paid Teaching Appointments)    **H** = Civilian Hospital Medical Staff Appointment  
**M** = Military Service (Including Hospital Staff Appointments)    **O** = Other

CODE	NAME AND ADDRESS OF ENTITY	DATE (From MO/YR to MO/YR)
------	----------------------------	----------------------------

**In the following section, please explain any gaps of two months or more in your education, post-graduate training or work history:**

**PROFESSIONAL LICENSES**

PROFESSIONAL LICENSES	LICENSE NUMBER	DATE OBTAINED	EXPIRATION DATE
STATE LICENSE			
FEDERAL DEA REG NUMBER			
STATE CDS LICENSE NUMBER			
CLIA CERTIFICATE			

Are laboratory testing procedures (as covered by the Clinical Improvement Act – CLIA) currently being performed at your office site where members are seen?

Yes  No **If yes, a current copy of your CLIA Registration must accompany this application.**

**FOR DENTISTS ONLY** - Do you perform any procedures in the office setting utilizing conscious sedation or any anesthesia (other than oral analgesic?)

Yes  No **If yes, a copy of your Anesthesia Permit must accompany this application.**

**Have you been or are you currently licensed in any other state? If YES, please complete the following:**

LICENSE NUMBER	STATE	DATE OBTAINED	EXPIRATION DATE

**(Please attach a copy of all licenses listed above and additional ones in other states not listed.)**

**REFERENCES**

**List, as professional references, three or more peers (Physicians of the same or similar specialty) who are familiar with your work effort and skills during the past two years.  
(References should not be relatives or current partners.)**

NAME SPECIALTY PHONE NUMBER

STREET ADDRESS CITY STATE ZIP

NAME SPECIALTY PHONE NUMBER

STREET ADDRESS CITY STATE ZIP

NAME SPECIALTY PHONE NUMBER

STREET ADDRESS CITY STATE ZIP

**PROFESSIONAL LIABILITY INSURANCE COVERAGE**

NAME OF CARRIER	POLICY NUMBER
ADDRESS AND PHONE NUMBER OF CARRIER	
AMOUNTS PER OCCURRENCE/AGGREGATE	DATES OF COVERAGE
Do you participate in the Louisiana Patients' Compensation Fund?	<input type="radio"/> YES <input type="radio"/> NO
Has current liability insurance carrier required exclusion of any procedures from insurance coverage? (If yes, attach explanation)	<input type="radio"/> YES <input type="radio"/> NO
Are you self-insured in accordance with the Louisiana Medical Malpractice Act?	<input type="radio"/> YES <input type="radio"/> NO

**Please attach a copy of the current Certificates of Insurance.**

**GENERAL QUESTIONS**

**Please check the appropriate response to the following questions:**

**If you answered YES to any of the questions below, please attach a full explanation on a separate page.**

	YES	NO	N/A
1. Has any disciplinary action ever been instituted against your license to practice in your profession in any state or country, or is any such action currently pending against you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has any disciplinary action ever been instituted against your DEA registration or CDS license, or have you voluntarily surrendered or limited your registration, or is any such action pending?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been convicted of, or pleaded nolo contendere to, or are you currently under investigation for federal or state felony or other criminal charge or have you ever served a prison sentence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have your clinical privileges at any hospital or health care institutions been voluntarily or involuntarily revoked, not renewed, or subjected to probationary or other disciplinary conditions, or has any proceeding been instituted or recommended by a hospital administration, medical staff committee or governing board?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever received a sanction from any regulatory agency (e.g., CLIA, OSHA, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you engaged in the illegal use of drugs within the past two years? "Illegal use of drugs" means the use of controlled substances obtained illegally, not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you currently have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you, your business entity or any family member have an ownership greater than 5% in any medical enterprise or business?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you presently a named defendant in a pending professional liability lawsuit?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES, please enter the number of cases _____ and attach a full explanation of each.			
11. During the past 5 years has any adverse medical review panel opinion been rendered, has any settlement or judgment been made, or has any payment been made by you or on your behalf in a professional liability action or potential action?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, please enter the number of cases \_\_\_\_\_ and attach a full explanation of each.

**REQUIRED ATTACHMENTS**

- ✓ State Licenses including current licenses held in other states, State CDS license and Federal DEA Registration
- ✓ Curriculum Vitae
- ✓ Certificate(s) of Professional Liability Insurance
- ✓ History of Malpractice suits in past 5 years, regardless of whether judgments or settlements paid.
- ✓ Explanation of any "Yes" Answer(s) from General Questions Section on page 8.
- ✓ Current Employer Identification Number (EIN) Letter, W-9 Form or Federal Tax Deposit Coupon
- ✓ Education Certificate for Foreign Medical Graduates (ECFMG) (If applicable)
- ✓ Health Plan Agreement (If applicable)

**STATEMENT TO APPLICANTS**

All providers applying for network participation have the right to review the credentialing application and supporting documents. Exceptions may vary as prohibited by law or health plan policy.

In the event that credentialing information obtained from other sources varies substantially from the information submitted on this application, you will be notified of the discrepancy either by telephone or in writing. You will have the opportunity to submit additional information to correct the discrepancy or provide clarification that might positively impact the credentialing decision.

According to La. R.S. 22:11.1.A (8) an adverse medical review panel opinion is included in the type of information a health plan may require you to submit on a credentialing or re-credentialing application.

According to La. R.S. 22:11.1, a health insurance issuer is required to complete the credentialing process within 90 days from the date of receipt of all information needed. The issuer is required to inform you within 30 days of receipt all defects and reasons known at the time in the event an application is deemed to be not correctly completed. The issuer is also required to inform you in the event that any needed verification or verification supporting statement has not been received from a third party within 60 days of the date of such a request.

**PROVIDER STATEMENT TO RELEASE INFORMATION**

All information and documentation submitted by me in this application is correct and complete to my best knowledge and belief.

I acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for network participation.

I consent to the release of all information that may be relevant to an evaluation of my credentials, including information about disciplinary actions or other confidential or privileged information, to Plan or its affiliates or successors. I understand and agree that this consent is irrevocable for any period during which I am Plan provider. I release Plan, its affiliates and successors and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my credentials. Plan is defined as the Health Plan that is requesting the credentialing information.

**X**

NAME (Please Print)

SIGNATURE

ORIGINAL ATTESTATION DATE

SECOND ATTESTATION DATE

THIRD ATTESTATION DATE

*Plan accreditation guidelines may require this application signature date to be no more than 180 days old at the time of credentialing.*

## Provider/Practice Enrollment Information

**Please complete all information to expedite enrollment**

**This form must be completed for EACH Practice applying for participation using the Primary Medicaid Provider Group Number**

<b>Medicaid Provider Group #:</b>	<b>NPI (for Practice):</b>	<b>TIN:</b>
<b>Enrollment Option:</b> _____ <small>(Please see attached sheet "Enrollment Options" and choose the option that best fits your practice. You may change this option by notifying your CHS-LA Provider Services Representative.)</small>	<b>Total # of patients currently in your Practice:</b> _____	<b>Practice Capacity:</b> _____ <small>Maximum capacity is 2,500 member per physician and 1,000 members per physician extender. You may change your Capacity by notifying your CHS-LA Provider Services Representative.</small>
<b>Is this Practice RHC or FQHC:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Are New Medicaid Patients Accepted?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Age Restrictions:</b>
<b>Office Hours:</b>		
<b>Legal Name:</b>		
<b>Practice Name:</b>		
<b>Primary Contact Name &amp; Title:</b>		
<b>Physical Address:</b>		
<b>Zip code +4</b>		
<b>Phone Number:</b>	<b>Fax Number:</b>	
<b>Mailing Address (If different than above):</b>		



## Enrollment Options

- 1 = **Accepts All:** Accepts new member choices as well as new auto assigned members. There is no restriction on the selections.
- 2 = **Accepts None:** Does not accept any new members either through member selection or by auto-assignments.
- 3 = **Member Choice Only:** Accepts only members who actively choose the practice.
- 4 = **Member Choice with Family:** Accepts only members who actively choose the practice if a member of the family is already enrolled with the practice.
- 5 = **Auto-Assignment with Family:** Accepts only auto-assignments if a member of the family is already enrolled with the practice.
- 6 = **Auto-Assignment Only:** Accepts auto-assigned members only.
- 7 = **Family Assign Only:** Accepts both Member Choice and Auto-Assignment if a member of the family is already enrolled with the practice.

**PLEASE SUBMIT YOUR CREDENTIALING APPLICATION TO CHS-LA  
VIA THE CAQH DATABASE.**

**IF YOU ARE NOT CURRENTLY A CAQH SUBSCRIBER, YOU CAN  
JOIN AT NO COST BY GOING TO [WWW.CAQH.ORG](http://WWW.CAQH.ORG).**

**PLEASE BE SURE TO ALLOW CHS-LA ACCESS TO YOUR  
CREDENTIALING MATERIAL.**



**PLEASE COMPLETE THE ATTACHED HARDCOPY CREDENTIALING  
APPLICATION ONLY IF YOU DO NOT HAVE ACCESS TO THE  
INTERNET.**

# COMMUNITY HEALTH SOLUTIONS OF AMERICA, LLC

## Agreement for Participation in Community Health Solutions of Louisiana Coordinated Care Network – Shared Savings Program

This Agreement effective \_\_ day of \_\_\_\_\_ 20\_\_ is between Community Health Solutions of America, LLC d/b/a Community Health Solutions of Louisiana hereinafter referred to as “CHS-LA” whose principal office is located in Saint Petersburg, Florida, and \_\_\_\_\_ located in the city of \_\_\_\_\_, parish of \_\_\_\_\_, State of Louisiana or State of \_\_\_\_\_ hereinafter referred to as the “CCN-S Provider.”

WHEREAS, CHS-LA, as a contracted Coordinated Care Network-Shared Savings Program with the Louisiana Department of Health and Hospitals is designated to establish and administer a program to provide medical assistance to the indigent under Title XIX of the Social Security Act, and is authorized to contract with health care providers for the provision of such assistance on a coordinated care basis;

NOW, THEREFORE, it is agreed between CHS-LA and the CCN-S Provider, as follows:

### **I. General Statement of Purpose and Intent**

CHS-LA desires to enter into an agreement with providers willing to participate in the Louisiana Medicaid Program to manage health care, provide primary care directly and to coordinate other health care needs through the appropriate referral and authorization of Medicaid services. CHS-LA applies to certain Medicaid recipients who may select or be assigned to the CCN-S Provider. This Agreement describes the terms and conditions under which this Agreement is made and the responsibilities of the parties thereto. A provider who enters into an agreement with CHS-LA for the purpose of delivering services for the CHS-LA Members is not restricted from subcontracting with another CCN or other managed care entity.

Except as herein specifically provided otherwise, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of this Agreement, and all rights of action relating to such enforcement, shall be strictly reserved to CHS-LA and the named CCN-S Provider. Nothing contained in this document shall give or allow any claim or right of action whatsoever by any other third person. It is the express intention of CHS-LA and CCN-S Provider that any such person or entity, other than CHS-LA or the CCN-S Provider, receiving services or benefits under this Agreement shall be deemed an incidental beneficiary only.

### **II. General Statement of the Law**

CHS-LA program is a Primary Care Case Management (PCCM) program implemented pursuant to 42 CFR 438.2, and is subject to the provisions of Louisiana Statutes and Louisiana Administrative Code 50: I Chapters 31-33. This Agreement shall be construed as supplementary to the usual terms and conditions of providers participating in the Medicaid program, except to the extent superseded by the specific terms of this agreement. The CCN-S Provider agrees to abide by all existing laws, rules, regulations, policies, and procedures set forth and pursuant to the CHS-LA and the Louisiana DHH Medicaid program.

The validity of this Agreement and any of its terms or provisions, as well as the rights and duties of the parties to this Agreement, are governed by the laws of Louisiana. The CCN-S Provider, by signing this Agreement, agrees and submits, solely for matters concerning this Agreement, to the exclusive jurisdiction of the courts of Louisiana and agrees, solely for such purpose, that the only venue for any legal proceedings shall be Baton Rouge, Louisiana.

### **III. Definitions - The following terms have the meaning stated for the purposes of this Agreement:**

Adjudicate – means to deny or pay a Clean Claim.

Action – A termination, suspension, or reduction (which includes denial of a service based on Federal Office of General Counsel interpretation of CFR 431) of Medicaid eligibility or covered services. It also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

Adverse Action – Any decision by the CCN to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested in accordance with 42 CFR § 438.214(c).

Adverse Determination – An admission, availability of care, continued stay or other health care service that has been reviewed by a CCN entity and based upon the information provided, does not meet the CCN's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced, suspended, delayed or terminated.

Appeal – A request for a review of an action pursuant to 42 CFR § 438.400(b).

Appeal Procedure – A formal process whereby a Member has the right to contest an adverse determination/action rendered by a CCN entity, which results in the denial, reduction, suspension, termination or delay of health care benefits/services. The appeal procedure shall be governed by Louisiana Medicaid rules and regulations and any and all applicable court orders and consent decrees.

Benefits or Covered Services – Those health care services to which an eligible Medicaid recipient is entitled under Louisiana Medicaid State Plan.

Board Certified – An individual who has successfully completed all prerequisites of a respective medical specialty board and has successfully passed the required examination for certification.

Care Coordination – Deliberate organization of patient care activities by a person or entity formally designated as primarily responsible for coordinated services furnished by providers involved in the Member's care to facilitate care within the network with services provided by non-network providers to ensure appropriate delivery of health care service. Organizing care requires the marshaling of personnel and other resources needed to carry out all required patient activities and is often managed by the exchange of information among participants responsible for different aspects of Member's care.

Care Coordinator – A person who is either a degreed social worker, licensed registered nurse, or a person with a minimum of two years' experience in providing case management services to persons who are elderly and/or persons with physical or developmental disabilities. Case management manager shall not provide direct care services to Members enrolled with the Contractor, but shall authorize appropriate services and/or refer Members to appropriate services.

Care Coordination Fee – The amount paid to the CCN-S Provider to handle coordination of care and other services as further defined in this Agreement. The amount paid is a per Member per month (PMPM) amount for each Member enrolled in CHS-LA and assigned to the CCN-S Provider.

Care Coordination Services Organization (CSO) – CSO shall be used to describe the entity providing the infrastructure to the Coordinated Care Network – Shared Savings Program. It is an experienced, responsive, responsible, and financially sound organization that provides infrastructure and support to the Network and the participating primary care practices.

Care Plan – An identification of Problems, Interventions and Goals to address problems or educational needs identified during assessment. It guides in the ongoing provision of care and assists in the evaluation of that care.

Chronic Care Management – The concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care.

Chronic Care Management Program – A system of coordinated health care in which interventions and communications for populations in which patient self-care efforts are significant. Chronic care management supports the physician or practitioner/patient relationship and plan or care; emphasizes prevention of exacerbation and complication of chronic diseases utilizing evidence based clinical practice guidelines, patient empowerment, and activation strategies that address co-morbidities through a whole person approach.

Claim – Means 1) a bill for services; 2) a line item of service or 3) all services for one recipient within a bill. A request for payment for benefits received or services rendered.

Clean Claim – Means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State’s claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

CMS 1500 – Universal claim form, required by CMS, to be used by non-institutional and institutional providers that do not use the UB-92.

Coordinated Care Network- Shared Savings (CCN-S) Network – An entity that serves as a primary care case manager by providing enhanced care management in addition to contracting with medical home or primary care providers (CCN-S Providers) for primary care management.

Coordinated Care Network – Shared Savings Member – An eligible person who has chosen or been assigned to a CCN-S plan.

Coordinated Care Network - Shared Savings Program Policy – All policies and procedures required by this Agreement and incorporated herein by reference are published in the *Community Health Solutions of Louisiana Handbook*.

Coordinated Care Network – Shared Savings Provider or CCN-S Provider – The Primary Care Provider (CCN-S Provider) or group of providers, who have agreed to serve as Primary Care Case Management (PCCM) providers, and other health care providers who partner with a CSO to accept the responsibility for providing medical homes for Members and for managing Members’ care per this agreement with CHS-LA.

Denied Claim – A claim for which no payment is made to the network provider by the CCN for any of several reasons, including but not limited to, the claim is for non-covered services, an ineligible provider or recipient, or is a duplicate of another transaction, or has failed to pass a significant requirement in the claims processing system.

Disease Specific Assessment (DSA) – systematic approach to collecting information from individuals related to a specific disease process and identification of concerns which may require interventions or education related to the disease.

Health Risk Assessment (HRA)- a systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease.

Grievance – An expression of dissatisfaction about any matter other than an action, as “action” is defined above. Possible subjects for grievance include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Members’ rights. The term is also used to refer to the overall system that includes CCN level grievance and access to State Fair Hearing.

Group Practice/Center – A Medicaid participating primary care provider structured as a group practice/center which (1) is a legal entity (e.g., corporation, partnership, etc.), (2) possesses a federal tax identification (employer) number, and (3) is designated as a group by means of a Medicaid Group Provider number.

KIDMED – Louisiana’s name for the screening component of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program provided for Medicaid eligible children under the age of 21. Required by the Omnibus Reconciliation Act of 1989 (OBRA 89).

Marketing – Any communication from a CCN-S Provider to a Medicaid or CHIP eligible that is not enrolled in the CCN-S that can reasonably be interpreted to influence the recipient to enroll in that particular CCN’s program or to not enroll in, or to disenroll from, another CCN’s program.

Medicaid – The Louisiana Medical Assistance Program. The medical assistance program authorized by Title XIX of the Social Security Act.

Medical Record – A single complete record kept at the site of the Member’s treatment(s), which documents all of the treatment plans developed, including, but not limited to, outpatient and emergency medical health care services whether provided by the CCN, its subcontractor, or any out-of-network providers. The records may be electronic, paper, magnetic material, film, or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 CFR § 456.111 and 42 CFR § 456.211.

Medically Necessary Services – According to LAC 50:I. 1101, those healthcare services that are in accordance with generally accepted, evidence-based standards medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: 1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted in or will result in a handicap, physical deformity or malfunction; and 2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis and treatment of that patient’s injury, illness or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational or cosmetic are specifically excluded from Medicaid coverage and will be deemed “not medically necessary.” The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing services on a case-by-case basis.

Member – Individuals who have been deemed eligible for assistance either through Title XIX (Medicaid) or Title XXI (CHIP) of the Social Security Act and that are enrolled in the CHS-LA CCN-S program.

Member Disenrollment – The deletion of the individual from the monthly list of Members furnished by CHS-LA to the CCN-S Provider.

Open Panel – CCN-S Providers who are accepting new patients for the Louisiana Medicaid CCN-S program.

Ownership Interest – The possession of stock, equity in the capital, or any interest in the profits of the CCN, for further definition see 42 CFR 455.101 (2005).

Performance Improvement Project – a project designed to achieve, through ongoing measurements and interventions, significant improvement sustained over time, with favorable effects on health outcomes and enrollee satisfaction.

Performance Measure Goals – Benchmarks for improvement on overall health status that will be set by DHH utilizing statewide Medicaid data.

Performance Measure Reporting – The methods by which the CCN shall collect, monitor and report data pertaining to performance goals as specified by DHH.

Potential Member – A Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet a Member of a specific CCN.

Preventive Care – Refers to the treatment to avert disease/illness and/or its consequences. The term is used to designate prevention or early detection programs rather than restorative or treatment programs. There are three levels of preventive care: primary, such as immunizations, aimed at preventing disease, secondary, aimed at early detection of disease, and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred. Requires a face-to-face visit within four weeks of Member's request.

Primary Care Services – Health care services and laboratory services customarily furnished by or through a primary care provider for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, health maintenance, and health promotion through direct service to the Member when possible, or appropriate referral to specialist or ancillary providers.

Prior Authorization – The process of determining medical necessity for specific services before they are rendered.

Prospective Review – Utilization review conducted prior to an admission or a course of treatment.

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

Protected Health Information (PHI) – Individually identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are identified in the Health Information Portability and Accountability Act or 1996 (HIPAA) 45 CFR Parts 160 and 164.

Provider Directory – A listing of health care service providers under contract with the CCN that is prepared by the CCN as a reference tool to assist Members in locating providers that are available to provide services.

Quality – As it pertains to external quality review means the degree to which a CCN increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Quality Assessment and Performance Improvement Program (QAPI Program) – Program that objectively and systematically defines, monitors and evaluates the quality and appropriateness of care and services and promotes improved patient outcomes through performance improvement projects, medical record audits, performance measures, surveys, and related activities.

Quality Assessment and Improvement (QAPI) Plan – A written plan, required of all CCN-S entities, detailing quality management and committee structure, performance measures, monitoring and evaluation process and improvement activities measures that rely upon quality monitoring implemented to improve health care outcomes for Members.

Quality Management (QM) – The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical and behavioral health knowledge.

Referral Services – Health care services provided to CCN Members to both in-and out-of-network when ordered and approved by the CCN, including, but not limited to, in network specialty care and out-of-network services which are covered under the Louisiana Medicaid State Plan.

Remittance Advice – An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only. Transactions may include, but are not limited to, Members enrolled in the CCN, payments for maternity, and adjustments.

School Based Health Centers (SBHC) – A health care provider certified by the Office of Public Health that is physically located in a school or on or near school grounds that provide convenient access to comprehensive, primary and preventive physical and mental health services for public school students.

Service Authorization – A utilization management activity that includes pre-concurrent or post review of a service by a health care professional to authorize, partially deny, or deny the payment of a service. Service authorization activities consistently apply review criteria.

Third Party Liability (TPL) – Any monetary amount due for all or part of the cost of medical health care from a responsible third party.

Utilization Management (UM) – The process to evaluate medical necessity, appropriateness, and efficiency of the delivery of health care services, procedures and facilities. UM is inclusive of utilization review and service authorization.

Utilization Review (UR) – Evaluation of the clinical necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings, and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective review.

Women, Infants, and Children (WIC) Program – Federal program administered by the Office of Public Health that provides nutritional counseling; nutritional education; breast-feeding promotion and nutritious foods to pregnant, postpartum and breast-feeding women and infants and children up to the age of five (5) who are determined to be at nutritional risk and who have a low to moderate income. An individual who is eligible for Medicaid is automatically income eligible for WIC benefits.

#### **IV. Functions and Duties of the CCN-S Provider**

##### **A. CCN-S Provider Participation Requirements.**

1. The CCN-S Provider shall be licensed and/or certified under applicable state and federal statutes and regulations and shall maintain this license/certification throughout the term of this Agreement. This includes all necessary licenses, certifications, registrations and permits as required to provide the health care services and/or other related activities designated by CHS-LA.
2. CCN-S Provider shall submit an on-line application through CAQH, and allow CHS-LA access, and meet CHS-LA credentialing and re-credentialing requirements in order to participate in the CHS-LA program. Failure to comply with CHS-LA credentialing policy and procedure as outlined in the *Community Health Solutions of Louisiana Handbook* may result in the termination of this Agreement and/or financial penalties.
3. CCN-S Provider shall notify CHS-LA of any and all changes to information provided on the initial application for participation.
4. CCN-S Provider shall conduct activities/actions in accordance with the Medical Assistance Program Integrity Law (MAPIL Louisiana R.S. Title 46, Chapter 3, Part VI-A) as required to protect the fiscal and programmatic integrity of the medical assistance programs.
5. CCN-S Provider will provide and update information which will be included in a directory that will be hardcopy, web-based and electronic. Required information includes names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the Members' service area, including identification of CCN-S Providers that are not accepting new patients, identification of any restrictions on the enrollee's freedom of choice among network providers, and identification of hours of operation including identification of non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours).

6. CCN-S Provider shall provide or arrange for Primary Care coverage in the amount, duration and scope of core benefits and services as specified in the Louisiana Medicaid State Plan, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week as defined by the *Community Health Solutions of Louisiana Handbook*. Automatic referral to the hospital emergency department for services does not satisfy this requirement. Members must be allowed to obtain emergency services outside the PCCM Network regardless of whether the CCN-S Provider referred the Member to the provider that furnished the services. The Rights of Members, as detailed in the *Community Health Solutions of Louisiana Handbook*, shall always be taken into account when rendering treatment.
7. CCN-S Provider agrees that services and/or supplies provided must be medically necessary and medically appropriate for each Member based on needs presented on the date the service is provided and/or delivered. Preventative, primary care and primary care coordination services shall be delivered to each Member as defined by *Community Health Solutions of Louisiana Handbook*.
8. CCN-S Provider shall safeguard information about Members (PHI and demographics) according to applicable state and federal laws and regulations.
9. CCN-S Provider shall adhere to the federal Health Insurance Portability and Accountability Act (HIPAA) and all applicable HIPAA regulations issued by the federal Department of Health and Human Services, including, but not limited to, the requirements and obligations imposed by those regulations regarding the conduct of electronic health care transactions and the protection of the privacy and security of individual health information and any additional regulatory requirements imposed under HIPAA;
10. CCN-S Provider shall establish and maintain hospital admitting privileges or a formal arrangement for management of inpatient hospital admissions of Members as defined by *Community Health Solutions of Louisiana Handbook*.
11. CCN-S Provider shall promptly arrange referrals for medically necessary health care services that are not provided directly and document referrals for specialty care in the medical record. Provide the authorization number to the referral provider either in writing or by telephone as defined by the *Community Health Solutions of Louisiana Handbook*.
12. CCN-S Provider shall authorize care for the Member or see the Member based on the standards of appointment availability as defined by the *Community Health Solutions of Louisiana Handbook*.
13. CCN-S Provider shall ensure that emergency services are coordinated without the requirement of prior authorization of any kind.
14. CCN-S Provider shall participate in activities that support acquisition of NCQA Patient-Centered Medical Home recognition.

## V. Medical Home or Primary Care Services.

### A. Practice Guidelines. CCN-S Provider will adopt practice guidelines that:

1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
2. Consider the needs of the individual Members.
3. Are adopted in consultation with applicable healthcare professionals, when indicated.
4. Are reviewed and updated periodically as appropriate.

### B. Non-Discrimination. The CCN-S Provider may not refuse to provide medically necessary or core preventive benefits and services to CCN Members specified under the contract between DHH and CHS-LA based on health status or need for health care services or for non-medical reasons (except those services allowable under federal law for religious or moral objections). CCN-S Provider will not discriminate in the rendering of service to individuals because of race, color, religion, sex, sexual orientation, age, national origin, handicap, political beliefs, or veteran status.

### C. Emergency Services. CCN-S Provider and CHS-LA will not be allowed to require prior authorization of any kind for emergency services.

- D. Medical Home Responsibilities.** CCN-S Provider shall serve as the Member's initial and most important point of interaction. Medical Home responsibilities include, at a minimum:
1. Managing the medical and health care needs of Members to assure that all medically necessary services are made available in a timely manner;
  2. Monitoring and follow-up on care provided by other medical services providers for diagnosis and treatment, to include services available under Medicaid Fee-For-Services;
  3. Providing the coordination necessary for the referral of patients to specialist and for the referral of patients to services that may be available through Medicaid Fee-For-Service;
  4. Providing for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for medical conditions and response, within thirty (30) minutes to after-hours calls;
  5. Providing case management services to include, but not be limited to, screening and assessment, development of a treatment plan of care to address risks and medical needs and other responsibilities; and
  6. Maintaining an adequate record system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to the CCN Members pursuant to this Agreement.
- E. Written Materials.** CCN-S Provider shall provide written materials that use easily understood language and format. Written material will be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. Make oral interpretation services available free of charge to each potential Member and Member. This applies to all non-English languages.
- F. Language Proficiency.** CCN-S Provider shall take adequate steps, including coordination with CHS-LA, to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided for by Louisiana Medicaid and in accordance with Title IV of the Civil Rights Act of 1964 (42 U.S.C. 200d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended).
- G. Enhanced Services.** The CCN-S Provider shall determine and coordinate the need for enhanced services that may be necessary for Members to maintain their health and well-being. As applicable to the CCN-S Providers' Member population, the following services will be provided:
1. **Early Periodic Screening, Diagnosis and Treatment (EPSDT).** Medicaid-eligible children under the age of twenty-one (21) shall receive EPSDT services. CCN-S Provider will provide services as outlined in the Louisiana DHH provider manual.
  2. **Adult Preventive Health Assessments.** CCN-S Providers are expected to provide all of the components of an initial preventive health assessment and periodic assessments to adult Members age 21 and over, consistent with adult physician exam requirements found in Louisiana DHH Physicians provider manual.
  3. **Women, Infants and Children (WIC).** CCN-S Providers are required to refer potentially eligible Members to the WIC program, with the Members' consent to the release of relevant medical records information.
- H. In-Office Laboratory Services.** In the event that the CCN-S Provider performs laboratory services, the CCN-S Provider must meet all applicable state requirements and 42 CFR § 493.1 and 493.3, and any other federal guidelines.
- I. Reporting Births.** CCN-S Provider will register all births that occur under their medical direction/supervision through LEERS (Louisiana Electronic Event Registration System) administered by DHH/Vital Records Registry.
- J. Conduct.** CCN-S Providers shall maintain reasonable standards of professional conduct and provide care in conformity with generally accepted medical practice following national and regional clinical practice guidelines or guidelines approved by CHS-LA and the Physician Advisory Board.

## VI. Functions and Duties of CHS-LA

### A. CHS-LA shall:

1. List the CCN-S Provider's name as a medical home or primary care provider in the CHS-LA CCN program.
2. Pay a management/coordination fee, in addition to the fee-for-service/encounter Medicaid payments received from DHH, on a per member per month basis, subject to the number of members enrolled with CHS-LA and assigned to the PCP/Practice. The amount of the management/coordination fee may be adjusted according to practice performance parameters as defined by CHS-LA. Multiple providers within a group practice are considered a single entity for purposes of the management/coordination fee.
3. Pay bonus monies to CCN-S Providers as outlined in Exhibit A and as further detailed in the *Community Health Solutions of Louisiana Handbook*.
4. Share savings as determined and calculated by DHH, will be shared with participating CCN-S Providers as outlined in Exhibit A and as further detailed in the *Community Health Solutions of Louisiana Handbook*.
5. Provide orientation, training and technical assistance to CCN-S Provider and staff regarding the CHS-LA CCN-S program which will be conducted on-site, telephonically, web-based or thru published bulletins.
6. Assign to the CCN-S Provider's practice a practice team composed of a Care Management Registered Nurse, a Louisiana based Provider Relations Representative and a telephonic Provider Relations Representative to assist in both operational and patient care issues.
7. Publish the *Community Health Solutions of Louisiana Handbook*, the Medicaid General and Special Bulletins. All such policies, procedures, Medicaid provider bulletins and manuals are incorporated into this agreement by reference.
8. Provide educational opportunities and Care Management support to CCN-S Providers to facilitate NCQA Patient-Centered Medical Home recognition.
9. Acknowledge that no provision contained in this Agreement or any Attachment restricts CCN-S Provider from contracting with another managed care entity.

## VII. Member Enrollment, Assignment, Participation and Disenrollment.

**A. Eligibility and Included Populations.** DHH determines eligibility for Medicaid and CHIP for all coverage groups except for Supplemental Security Income (SSI), Family Independence Temporary Assistance Program (FITAP), and Foster Care. The Social Security Administration (SSA) determines eligibility for SSI and the Department of Social Services (DSS) determines eligibility for FITAP and Foster Care. Once an applicant is determined eligible for Medicaid or CHIP by DHH, DSS, or SSA, the pertinent eligibility information is entered in the Medicaid Eligibility Determination System (MEDS). Eligibility criteria for the Louisiana Medicaid CCN Program are the same as the eligibility criteria for the Louisiana Medicaid and CHIP Programs. (Reference the *Community Health Solutions of Louisiana Handbook* for specific included population information.)

### B. CHS-LA shall:

1. Provide the CCN-S Provider with a monthly list of Members who have selected or have been assigned to him/her for the purpose of managing their health care needs.
2. Provide program education to all Members through various means as approved by DHH. The recipient will receive accurate oral and written information needed to make an informed decision on whether to enroll.

3. Provide potential members and members with member handbook that contains program information including member rights and protections, program advantages, member responsibilities, complaint and grievance instructions.
4. Notify members that oral interpretation is available for any language and written material is available in prevalent languages and how to access these services.
5. Provide written materials that use easily understood language and format. Written material will be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
6. Inform members and potential members that information is available in alternative formats and how to access those formats. Provide members with written notice of any significant program change at least thirty (30) days before the intended effective date of the change.
7. Not prohibit or otherwise restrict CCN-S Provider from advising a Member about the health status of the Member or medical care or treatment from the Member's condition or disease, regardless of whether benefits for such care or treatment are provided under this Agreement, if CCN- Provider is acting within the lawful scope of practice.

**C. CCN-S Providers shall:**

1. Accept Members pursuant to the terms of this Agreement and be listed as a Medical Home provider in the CHS-LA CCN-S program for the purpose of providing care to Members and managing their health care needs;
2. Not encourage or suggest, in any way, that a Member be placed in state custody in order to receive medical or specialized behavioral health services covered by DHH;
3. Be familiar with and comply with Enrollment, Assignment and Disenrollment processes articulated in the *Community Health Solutions of Louisiana Handbook* including maximum number of Members allowed by DHH that can be linked or assigned to the CCN-S Provider;
4. Provide written notice to CHS-LA in the event that CCN-S Provider determines that they cannot accept or continue to treat a patient with whom the CCN-S Provider feels that they cannot establish and/or maintain a professional relationship. To ensure continuity of care, the CCN-S Provider will continue to serve as the Member's medical home until the Member can be properly and appropriately transferred to a new medical home.
5. Transfer the Member's medical record to the receiving provider upon the change of medical home/primary care provider at the request of the new CCN-S Provider and as authorized by the Member within thirty (30) days of the date of the request.

**D. Verification of Eligibility.** CCN-S Provider will review and use the monthly enrollment report as required by the *Community Health Solutions of Louisiana Handbook*. A signed *Document Distribution System User Agreement* is required for online access to these reports. Provider may also utilize DHH's system for verifying a Member's participation. This verification should occur prior to services being rendered.

**E. Marketing.**

1. CHS-LA shall:
  - a. Provide marketing materials to potential members.
  - b. Develop and distribute to CCN-S Provider marketing materials reviewed and approved by DHH.
  - c. Not make any assertion or statement (whether written or oral) in marketing materials that the recipient must enroll with the CCN-S Provider in order to obtain benefits or in order not to lose benefits.
  - d. Not make any assertion or statement that the CCN-S Provider is endorsed by CMS, the Federal or State government or similar entity.
2. Specific to marketing associated with CHS-LA plan, CCN-S Provider shall:
  - a. Receive prior approval from CHS-LA of any marketing materials prior to distribution.
  - b. Not make any assertion or statement (whether written or oral) in marketing materials that the recipient must enroll with the CCN-S Provider in order to obtain benefits or in order not to lose benefits.
  - c. Not make any assertion or statement that the CCN-S Provider is endorsed by CMS, the Federal or State government or similar entity.

3. Specific to marketing associated with CHS-LA plan, CHS-LA and CCN-S Provider must refrain from door-to-door, telephonic or other 'cold-call' marketing; engaging in marketing activities that could mislead, confuse, or defraud Medicaid Recipients, or misrepresent the CCN-S Provider, its marketing representatives, or CHS-LA.

## **VIII. Care Management.**

**A. Care Plans.** CHS-LA and CCN-S Provider are jointly responsible for the planning, directing and coordinating of health care needs and services for Members assigned.

**B. CHS-LA agrees to:**

1. Assess the Member's individual care needs through a Health Risk Assessment (HRA), Disease Specific Assessment (DSA) and a thorough clinical assessment of primary and comorbid conditions that define the individuals care needs, Clinical Risk Assessment (CRA).
2. Provide CCN-S Provider with a draft Care Plan for review and approval Member's identified as needing care coordination services.
3. Assess availability and facilitate the delivery of comprehensive, medically necessary health care services/resources to eligible Members for individual care needs.
4. Work collaboratively with CCN-S Providers to encourage Members to appropriately access and utilize their medical home of choice.
5. Provide Member education on individual care needs that promote awareness of disease process, promote maintenance or improvement of clinical and functional status, promote appropriate utilization of health care resources and encourage compliance with the CCN-S Provider approved Care Plan.
6. Serve as a Member advocate in accessing health care resources necessary to improve or stabilize clinical status and functional status.
7. Coordinate all Care Management activities with other CHS-LA plan activities (i.e. Member Services, Provider Services, and Quality Improvement).
8. Provide 24/7 clinical support to Members via the 24 Hour Hot Line.

**C. CCN-S Provider agrees to:**

1. Review, modify, if necessary, and approve, Member specific Care Plans. These activities must include assessment, scheduling assistance, monitoring and follow-up of Member(s) needing or requiring both medical and behavioral health services.
2. Implement Member specific management Milliman CareGuidelines, (current edition) and/or will refer Members for Care Coordination and/or Disease Education when indicated such as when the following are identified:
  - a. Unstable acute or chronic illness
  - b. Following discharge from hospital or recovery facility
  - c. Following Emergency Room utilization
  - d. Medication non-compliance or educational assistance
  - e. Assistance with payer source or community resource needs
  - f. Non-compliance with treatment recommendations which may benefit from education
  - g. Diagnosis of one or more chronic disease conditions which would benefit from disease management and / or education including, but not limited to Coronary Artery Disease, Congestive Heart Failure, Asthma, Diabetes, COPD.
  - h. Chronic medical condition with psychiatric comorbidity or substance abuse / dependence
  - i. Refer for a second opinion as defined by *Community Health Solutions of Louisiana Handbook*.
  - j. Marginal or inadequate health literacy.
  - k. Suspected or identified psychosocial issues.
  - l. Maternity with high risk indicators, case management or educational needs.

3. Make referrals to care management for Member's assigned to their practice who may benefit from care management services.

**D. Referrals.** CCN-S Providers are required to either provide medically necessary services or authorize a timely and appropriate referral to another provider to evaluate and / or treat the Member. Referral authorizations and consultations, including referrals authorized retrospectively, are the discretion of the CCN-S Provider. The CCN-S Provider shall provide the coordination necessary for referral as appropriate of CCN-S members for those services that are available through fee-for-service Medicaid providers, including but not limited to:

1. Specialty Physician
2. Hospitals
3. Lab
4. X-Rays
5. Ancillary service providers
6. Home health
7. Services provided through DHH Early Step Services
8. Dental Services.
9. Personal Care Services (EPSDT and LT-PCS)
10. Intermediate Care Facilities for the Developmentally Disabled
11. Home and Community Based Waiver Services
12. School-based Individualized Education
13. Hospice Services
14. Non-Emergency Transportation
15. Nursing Facility Services
16. Pharmacy (Drug Prescriptions)
17. Specialized Behavioral Health Services
18. Targeted Case Management
19. Durable Medical Equipment
20. Prosthetics and Orthotics

Referral to specialist can be performed telephonically or in writing. The referral should include the number of visits authorized and the extent of the diagnostic evaluation. Referrals must be documented in the Members medical record and include follow up related to care provided by referral provider. Specialist referral to a second specialist for the same diagnosis requires CCN-S Provider authorization.

**E. Service Authorizations.** Service authorizations include, but are not limited to, prior authorizations, concurrent authorization, and retrospective authorization. The CCN-S provider shall obtain authorization for those services that require authorization under the Medicaid FFS System

**F. Lawful Scope of Practice.** CHS-LA shall not prohibit or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is their patient {1932(b)(3)(d), 42 CFR §438.102(a)(1)(i),(ii),(iii) and (iv)}: a) for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; b) for any information the enrollee needs in order to decide among all relevant treatment options; c) for the risks, benefits, and consequences or treatment or non-treatment; and d) for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

**G. Transportation.** If necessary, CCN-S Provider will assist with the coordination of transportation for the Member.

**H. Report Reviews.** Review and use all Member utilization and cost reports provided by the CHS-LA for the purpose of practice level utilization management and advise CHS-LA of errors, omissions, or discrepancies found within the reports.

## **IX. Quality Programs.**

### **A. CHS-LA agrees to:**

1. Provide an ongoing quality assurance/improvement program to manage and measure the quality of health care services rendered to Members.
2. Provide the CCN-S Provider with regular performance, utilization and cost reports.
3. Gather and analyze data relating to service utilization by members to determine whether CCN-S Providers are within acceptable medical homes peer comparison parameters.
4. Participate and cooperate with announced or unannounced internal or external quality assessment reviews, utilization review, grievance procedures and performance improvement projects and activities as well as medical record review as established by DHH and/or its designee as it relates to services provided and accessible health care to CCN-S Members.

### **B. The CCN-S Provider agrees to:**

1. Participate and cooperate with announced or unannounced internal or external quality assessment reviews, utilization review, grievance procedures and performance improvement projects and activities as well as medical record review as established by CHS-LA, DHH and/or its designee as it relates to services provided and accessible health care to CCN-S Members.
2. Participate in quality management activities including peer review by providing prompt response to any request for records or recommendations for any detected deficiencies or agreement violations and for the development of corrective action initiatives relating to this agreement.
3. Submit all reports and clinical information required by CHS-LA for reporting purposes such as HEDIS, AHRQ, CHIPRA, and EPSDT.
4. Adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined in the *Community Health Solutions of Louisiana Handbook*. Participate and cooperate with CHS-LA utilization management, quality assessment, and administrative programs.

**C. Corrective Action Plan.** CHS-LA will monitor and report the quality of services being rendered under this Agreement. The CCN-S Provider agrees to accept and comply with any plan of correction if necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the provider practices.

**D. Orientation.** CHS-LA shall offer and CCN-S Provider shall participate in mandatory CHS-LA Orientation meeting(s) during which program and operational guidelines will be explained. On an annual basis thereafter, participate in the CHS-LA meeting during which Comparative Performance Parameters will be reviewed as well as any program updates and/or changes. These will be organized in such a fashion that the CCN-S Provider can submit their attendance and participation to their respective professional organizations/associations.

**E. Medical Records.** CCN-S Provider shall maintain:

1. An adequate Member record system (whether electronic or paper) for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Members (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness and timeliness of services performed under CHS-LA's contract with DHH. Members and their representatives shall be given access to and can require copies of the Members' medical records, to the extent and in the manner provided by LRS 40:1299.96 and 45 CFR.164.524.
2. A unified patient medical record for each Member following the medical record documentation guidelines as defined by *Community Health Solutions of Louisiana Handbook*.
3. All Member records including but not limited to administrative, financial, and medical will be retained (whether electronic or paper) for a period of six (6) years after the last payment is made for services provided to a member and retained further if the records are under review, audit, or related to any matter in litigation until the review, audit or litigation is complete. The exception to this requirement shall include records pertaining to once-in-a-lifetime events such as, but not limited to,

appendectomy and amputations, etc. which must be maintained indefinitely and may not be destroyed. This provision pertains to the retention of records for Medicaid purposes only; other state or federal rules may require longer retention periods and are further defined in LRS 40:1299.96.

4. CHS-LA and CCN-S Provider agree to maintain all records originated or prepared in connection with this Agreement and the performance of the obligations under including but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by both parties in accordance with the terms and conditions of the CHS-LA's contract with DHH. CCN-S Provider agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Members relating to the delivery of care or service to Members of CHS-LA for a period of six (6) years from the expiration date of the contract between DHH and CHS-LA, including any contract extension(s). If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the six (6) year period, whichever is later.

**F. Fraud and Abuse Reporting.** CCN-S Provider shall participate in the CHS-LA Compliance / Program Integrity Plan in order to ensure that all complaints for suspected fraud or abuse are reviewed and investigated in a timely manner and that fraud referrals are made when appropriate. CCN-S Provider's shall report any suspected fraud or abuse by a CCN-S Program Member, provider or sub-contractor by calling 866-255-1154.

**G. Grievance and Appeals.** CHS-LA has a grievance system in place which complies with all federal and state requirements set forth in 42 CFR §431.200 and 42 CFR §§438.400 through 438.424. CCN-S Provider will comply with this regulation including CCN-S Provider grievance and appeals as well as facilitating Member grievance and appeals by offering access to the Member or their designated representative to the Louisiana State's Fair Hearing Process and routine reporting of compliance, grievances and appeals to the Louisiana DHH. CCN-S Provider may file a grievance or request a State Fair Hearing on behalf of a member in response to an action. No punitive action will be taken against a provider who files on behalf of a Member.

CHS-LA will maintain a monitoring system to receive and respond in a timely manner to complaints and grievances, and, when appropriate, inform CCN-S Providers and/or Members of their rights to submit an appeal and have access to the Louisiana State Fair Hearing Process. The information and instructions for initiating the process can be found in the *Community Health Solutions of Louisiana Handbook*, CHS-LA Member materials, including the Member Welcome Packet and the Member Handbook, as well as on the CHS-LA website.

## **X. Claims Submission, Processing and Payment**

### **A. CHS-LA will be responsible for:**

1. Maintaining a system to accept paper or electronic claims from the CCN-S Provider.
2. Complying with the final Health Insurance Portability and Accountability Act (HIPAA) rule, which named the ICD-9-CM Volume 3 Procedure Codes (including The Official ICD-9-CM Guidelines for Coding and Reporting) the HCPCS/CPT codes as the HIPAA standard medical code set for physician services and other health care services.
3. Making available to the CCN-S Provider information on claims status as identified in the *Community Health Solutions of Louisiana Handbook*.
4. Timely preprocessing CCN-S Provider's claims and forwarding those claims to DHH and/or their agent for payment.

### **B. CCN-S Provider will be responsible for:**

1. Submitting to CHS-LA complete and accurate claims information in a billing form acceptable to DHH. All clean claims must be submitted no later than three hundred sixty five (365) days from the

- date of service. The CCN-S Provider shall provide the name and address of the official payee to whom payment shall be made.
2. Certification and Attestation that all services provided to Members for which a claim is being submitted will be necessary, medically needed and will be rendered by CCN-S Provider or under their personal supervision;
  3. Certification and Attestation that all claims submitted to Louisiana Medicaid by CHS-LA on behalf of CCN-S Provider will be paid and satisfied from federal and state funds, and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws;
  4. Certification and Attestation that all claims submitted under the conditions of this Agreement are certified to be true, accurate, and complete.
- C. Compensation.** CCN-S Provider shall disclose the method and amount of compensation or other consideration to be received from DHH. DHH shall remain responsible for payment of claims submitted which shall not be in amount less than the published Medicaid fee-for-service rate in effect on the date of services.
- D. Member Non-Liability.** CCN-S Provider shall accept payment made by Louisiana DHH as payment in full for Members' covered services provided under this Agreement and shall not solicit or accept any surety or guarantee of payment from the Member other than applicable copayments. Member shall include the patient, parent(s), guardian, spouse, or any other person legally responsible for the Member being served.
- E. Prohibited Payments.** CHS-LA is prohibited from making payments to CCN-S Providers or other subcontractors for the provision of medical assistance for health care-acquired conditions and other provider-preventable conditions as may be identified by DHH.

## **XI. General Terms and Conditions**

- A. Non-Exclusive Agreement.** CCN-S Provider may participate in any other alternative delivery system, network or CCN program and provide health care services independent of and apart from the services being rendered under this Agreement. CCN-S Provider may contract with any other program as deemed appropriate without prior consent of approval by CHS-LA.
- B. Entire Agreement.** This Agreement, together with all attachments, exhibits, and references, contains all the terms and conditions agreed upon by the parties, and supersede all other agreements, express or implied relating to the subject matter hereof between the parties.
- C. Amendments.** With the exception of any Care Coordination processes, Credentialing standards, DHH Companion Guides or *Community Health Solutions of Louisiana Handbook* this Agreement nor any of its Exhibits may be altered, varied, modified, waived, or extended at any time except by mutual written agreement of the parties. The parties shall make no modification or change any provision of the Agreement or Attachments unless such modification is incorporated and attached as a written amendment to the Agreement and signed by both parties.

This Agreement and any of its Attachments may also be amended by CHS-LA through CCN-S bulletins or by furnishing CCN-S Provider with written notice of any proposed amendments or modifications. Such amendments or modifications shall be deemed accepted and incorporated into this Agreement unless CCN-S Provider rejects the amendment or modification in writing within thirty (30) days of having received notice of it from CHS-LA.

- D. Interpretation.** The validity, enforceability and interpretation of any of the clauses of this Agreement shall be determined and governed by applicable Louisiana law as well as applicable federal laws. In the event of any conflict between this Agreement and the contract between CHS-LA and DHH, the CHS-LA and DHH Agreement shall govern. The parties agree that jurisdiction for any legal action regarding this Agreement shall be in the state or federal courts in Baton Rouge, Louisiana. Members shall not be third party beneficiaries to this Agreement.

- E. Severability.** The illegality, unenforceability or ineffectiveness of any provision of this Agreement shall not affect the legality, enforceability or effectiveness on any other provision of this Agreement.
- F. Government Program Regulatory Requirements.** Each party agrees that each shall comply with all applicable laws, regulations and administrative rules that apply to all persons or entities receiving state and federal funds and bear upon the subject matters of this Agreement, including, but not limited to, the following provisions:
1. All revisions of such laws, rules, or regulations shall automatically be incorporated into the CCN-S Provider's Agreement as they become effective during the terms of this Agreement. This includes, but is not limited to Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations. The CCN-S Provider shall be bound by Medicaid policy as stated in applicable provider manual and in the *Community Health Solutions of Louisiana Handbook*.
  2. Compliance with state and federal anti-discrimination laws and equal employment opportunity: Title 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; Section 202 of Executive Order 11246, as amended, and all applicable requirements imposed by or pursuant to the regulations of the U.S. department of Health and Human Services.
    - a. In the event that changes in this Agreement as a result in changes in federal or state law materially affect the position of either party, CHS-LA and the CCN-S Provider agree to negotiate such further amendments as may be necessary to correct any inequities.
- G. Audits and Inspections.** CCN-S Provider shall allow CHS-LA or its duly authorized representative, DHH, U.S. Department of Health and Human Services, (HHS), CMS, Office of Inspector General Comptroller, State Legislative Auditor's Office, and the Louisiana Attorney General's Office the right to unlimited access (including on-site inspections and review) and the right to evaluate through audit, inspection, or other means, whether announced or unannounced, any records pertinent to the contract between DHH and CHS-LA, including quality, appropriateness and timeliness of services and the timeliness and accuracy of practitioner claims submitted to the CCN relating to the provision of services under this agreement as required by Medicaid policy and 42 CFR 431.107. Such evaluation, when performed, shall be performed with the cooperation of CHS-LA and with CHS-LA's assistance, if requested.
- If CCN-S Provider stores records on microfilm or microfiche or other electronic means, CCN-S Provider agrees to produce, at their expense, legible hard copy records upon the request of state or federal authorities, within twenty-one (21) days of the request.
- H. Indemnification and Hold Harmless.** The CCN-S Provider shall indemnify and hold DHH and CHS-LA harmless from and against any and all debts for CCN-S Provider and from any and all claims, damages, causes of action, suits, expenses or liabilities to the extent proximately caused by or which may arise out of and/or be incurred in connection with, any negligent or other wrongful conduct arising relating to activities undertaken pursuant to this Agreement or the contract between DHH and CHS-LA. This section shall survive the termination of this Agreement for any reason, including insolvency.
- I. Subcontracting or Assigning.** The CCN-S Provider shall not subcontract or assign any of the work contemplated under this Agreement without prior written approval from CHS-LA. Any approved subcontract shall be subject to all conditions of this Agreement. If approved, the CCN-S Provider shall be responsible for the performance of any subcontractor. CHS-LA shall not be responsible to pay for work performed by unapproved subcontractors.
- J. Independent Subcontractor.** The CCN-S Provider is and shall be deemed to be an independent subcontractor in the performance of this agreement and as such shall be wholly responsible for the work to be performed and for the supervision of its employees. The CCN-S Provider represents that it has, or shall secure at its own expense, all personnel required in performing the services under this Agreement.

**K. Ownership Disclosure Information.** Under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of each person, entity or business with an ownership or control interest in the disclosing entity. (See *Federal Regulations 42 CFR § 455.104(a) (1), (2)*). A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether any person, entity or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling. (See *Federal Regulations 42 CFR § 455.104(a)(2)*). Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the provider/ disclosing entity also has an ownership or control interest. CCN-S Provider shall complete and return the form found in Exhibit C of this Agreement.

**L. Insurances.** CCN-S Provider agrees to maintain in force such policies as follows:

1. General and professional liability (malpractice) insurance, as shall be necessary, to insure CCN-S Provider and their employees against any claim(s) for damages arising by reason of personal injuries or death occasioned, directly or indirectly, in connection with the performance of any service by CCN-S Provider. The amounts and extent of such malpractice insurance coverage shall be subject to the approval of CHS-LA and shall not be less than \$100,000 per claim, \$300,000 aggregate per year or as otherwise required by applicable laws or regulations. CCN-S Provider shall provide copies of such insurance coverage to CHS-LA upon request.
2. Workers' compensation insurance to cover all employees as required by applicable state laws but, in no event to an amount less than \$100,000 per incident/accident.
3. CCN-S Provider further agrees that CHS-LA shall be given thirty (30) days prior written notice of cancellation or termination of CCN-S Provider's insurance policies. In the event of such cancellation and/or termination, CHS-LA may terminate this Agreement effective immediately upon CCN-S Provider's receipt of written notice from CHS-LA.

**M. Notifications.** CHS-LA shall be immediately notified in writing by certified mail by CCN-S Provider or their legal representative of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the provider's ability to perform the services included in this contract.

**N. Transfer of Agreement.** This Agreement may not be transferred by CCN-S Provider without prior written consent of CHS-LA.

**O. Dispute Resolution.** If any dispute shall arise under the terms of this Agreement between CHS-LA and the CCN-S Provider, the sole and exclusive remedy shall be the filing of a Notice of Appeal within thirty (30) days of receipt of written notice of CHS-LA's action or decision which forms the basis of the appeal. Administrative appeals shall be in accordance with Louisiana DHH's regulations. CHS-LA and the CCN-S Providers shall resolve any disputes that may arise between them in such a way that there will be no disruption or interference with the provision of services to enrolled Members.

**P. Notice.** Any notice required to be given pursuant to the terms and provisions hereof shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, or by recognized courier service, addressed as follows:

If to CHS-LA  
5145 Bluebonnet Blvd., Suite B  
Baton Rouge, LA 70809

If to CCN-S: Provider \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_

**Q. Force Majeure.** Neither party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of a public enemy, war, accident, fire, explosion, earthquake, flood, strikes or other work stoppages by either party's employees, or any other similar cause beyond the reasonable control of such party.

- R. Confidentiality.** Any information maintained or generated by either party in fulfillment of its obligations under this Agreement, including healthcare information, shall be kept confidential in accordance with and to the extent required by applicable laws. Further, all information provided to CCN-S provider, including, but not limited to, Beneficiary lists, QA Protocols, credentialing criteria, compensation methodologies and rates, and any other administrative protocols or procedures of CHS-LA, is the proprietary property of CHS. CCN-LA Provider shall not disclose or release such material to any third party without the written consent of CHS-LA.
- S. Conflict Of Interest.** If any requirement found in this Agreement is determined by DHH to be in conflict with the contract between DHH and CHS-LA, such requirement shall be null and void and all other provisions shall remain in full force and effect.
- T. Compliance with Law.** Comply with all Federal and State laws and regulations including Title 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; Section 202 of Executive Order 11246, as amended, and all applicable requirements imposed by or pursuant to the regulations of the U.S. department of Health and Human Services.

## **XII. Term and Termination**

- A. Term.** This Agreement will commence as of the Effective Date and will continue for a period of three (3) years.
- B. Termination Without Cause.** This Agreement may be terminated without cause by either party upon a ninety (90) days advance written notice to the other party.
- C. Termination for Failure to Re-credential.** CCN-S Provider will be subject to recredentialing by CHS-LA. If CCN-S Provider fails to submit the appropriate documents for recredentialing for all CCN-S Providers under this Agreement, then this Agreement may be subject to termination within thirty (3) days of when the current credentialing expires. At the least, the CCN-Provider(s) whose recredentialing materials are not received, will be terminated within thirty (30) days of their expiration date.
- D. Termination for Cause.** Either party may terminate this Agreement if the other party fails to cure the default or material breach within thirty (30) days of receipt of written notice of the default or breach from the non-defaulting/non-breaching party. In addition CHS-LA may terminate this Agreement immediately in the event of the occurrence of any of the following events:
  - 1. Any license, certification, registration, permit or approval that is reasonably required of a CCN-S Provider to provide health care services is revoked, suspended, or restricted;
  - 2. CCN-S Provider fails to maintain general, professional liability insurance as required under this Agreement;
  - 3. CHS-LA determines that one or more Member's health is impaired by the continued participation of the CCN-S Provider;
  - 4. DHH terminates its contract with CHS-LA.
- E. Immediate Termination.** CHS-LA under the following conditions, may terminate this agreement immediately:
  - 1. In the event that state or federal funds that have been allocated to CHS-LA are eliminated or reduced to such an extent that, in the sole determination of CHS-LA, continuation of the obligations at the levels stated herein may not be maintained. The obligations of each party shall be terminated to the extent specified in the notice of termination immediately upon receipt of notice of termination from CHS-LA; or
  - 2. If the CCN-S Provider (a) is determined to be in violation of terms of this agreement, or applicable federal and state laws, regulations, and policy, and/or (b) fails to maintain program certification or

licensure; or upon the death of the CCN-S Provider, the sale of the CCN-S Provider's practice, or termination of participation as a Medicaid or Medicare provider;

3. If the CCN-S Provider fails to disclose any ownership changes within thirty-five (35) calendar days, in accordance with 42 CFR 455.104 (2000, as amended).
4. In the event of conduct by the CCN-S Provider justifying termination, including but not limited to breach of confidentiality or any other covenant in this agreement, and/or failure to perform designated services for any reason other than illness.

**F. Cooperation with Transition of Care.** In the event of termination of this Agreement CCN-S Provider agrees to assist CHS-LA in arranging for an orderly transition of patient care, consistent with standards of quality medical care, for Member who have been or are at the time under the care of or assigned to the CCN-S Provider. CCN-Provider will continue to provide health care services under the terms of this Agreement until such time as the Members can be successfully transferred to another participating CCN-S Provider.

**G. Obligations after Termination.** Except as otherwise provided in this Agreement, the provisions of this Agreement will be of no further force or effect following termination of this Agreement, provided that each party will remain liable for any obligations or liabilities arising from activities carried on by the party prior to the effective date of termination. Additionally, CHS-LA and the CCN-S Provider recognize that in the event of termination of the contract between DHH and CHS-LA, CHS-LA shall immediately make available to DHH or its designated representative, in a usable form, any and all records, whether medical or financial, related to CHS-LA's and CCN-S Provider's activities pursuant to this Agreement. The provision of such records shall be done at no expense to DHH.

**XIII. Signatories:**

IN WITNESS WHEREOF, CHS-LA and the CCN-S Provider, by their authorized agents, agree to all terms and conditions in this agreement and its appendices and have executed this Contract as of the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_ and shall be effective the \_\_\_ day of \_\_\_\_\_, 20\_\_

Community Health Solutions of America, LLC  
d/b/a Community Health Solutions of Louisiana

\_\_\_\_\_  
(Practice or CCN-S Provider Name)

BY: \_\_\_\_\_

BY: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Print Name: \_\_\_\_\_

Print Title: \_\_\_\_\_

Date of Execution: \_\_\_\_\_

Date of Termination: \_\_\_\_\_

## Exhibit A

### **Management/Coordination Fees Bonus Payments Shared Savings Distribution Claim Processing**

The services provided under this Agreement must be in accordance with the Louisiana Medicaid State Plan and require that CCN-S Provider shall provide these services to Members through the last day that this Agreement is in effect. All final Medicaid benefit determinations are within the sole and exclusive authority of DHH or its designee.

NOTE: CHS-LA, in accordance with 42 CFR §438.210(e) is not compensated nor structures CCN-S Provider compensation as to provide incentives for either CHS-LA or CCN-S Provider to deny, limit, or discontinue medically necessary services to any Member.

#### **Management/Coordination Fees**

CHS-LA will pay to the CCN-S Provider a prospective management/coordination fee of no less than \$1.50 per member per month for each Member in the CHS-LA program assigned to their practice by DHH. This fee will be paid to the CHS-LA Provider within seven (7) business days of CHS-LA's receipt of the funds from DHH.

For SSI Members an additional \$.50 will be paid to CCN-S Providers to manage the complexity of the care for this population.

#### **Bonus Payments**

CHS-LA will make bonus payments to the CCN-S Providers for all populations and age as follows:

Extended Hours – Access and Availability	\$.25 pmpm
Urgent Care Services – Access and Availability	\$.25 pmpm
Membership 500-999 members- Access	\$.50 pmpm
Membership 1000+ members- Access	\$1.00 pmpm

Specific requirements for receiving bonus payments shall be articulated in the *Community Health Solutions of Louisiana Handbook*.

#### **Shared Savings Distribution**

Demonstrated Savings shall be determined by DHH. CHS-LA will distribute 50% of the Demonstrated savings to providers. Distribution of Shared Savings to CCN-S Providers shall be made within thirty (30) days of disbursement to CHS-LA by DHH, based upon Provider adherence to DHH's requirements. Specific requirements for receiving Shared Saving shall be articulated in the *Community Health Solutions of Louisiana Handbook*.

#### **Official Payee**

CHS-LA shall make payment only to the official payee as designated by the completed and signed W-9 (see Exhibit B) which will be kept on file.

#### **Claims Payments**

CHS-LA is responsible for the pre-processing of the claims for Members in the CHS-LA program. All claims, once pre-processed will be forwarded to DHH or their designee for payment. CCN-S Providers will receive payment from DHH in accordance with the terms of their Medicaid agreement.

**EXHIBIT B**  
**W-9 Form**

**Visit irs.gov for instructions on completing the W-9 form.**

<p><b>Form W-9</b> (Rev. October 2007) Department of the Treasury Internal Revenue Service</p>	<p><b>Request for Taxpayer Identification Number and Certification</b></p>	<p><b>Give form to the requester. Do not send to the IRS.</b></p>
<p>Print or type See Specific Instructions on page 2.</p>	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ..... <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional) Community Health Solutions of America, LLC dba Community Health Solutions of Louisiana 1000 118th Avenue North St. Petersburg, FL 33716-2332
	City, state, and ZIP code	
List account number(s) here (optional)		

**Part I Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
OR
Employer identification number

**Part II Certification**

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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**General Instructions**

Section references are to the Internal Revenue Code unless otherwise noted.

**Purpose of Form**

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

**EXHIBIT C**

## Ownership Disclosure Information

Under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of each person, entity or business with an ownership or control interest in the disclosing entity. (See *Federal Regulations 42 CFR § 455.104(a) (1)*), (2). A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether any person, entity or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling. (See *Federal Regulations 42 CFR § 455.104(a)(2)*). Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the provider/ disclosing entity also has an ownership or control interest.

### INSTRUCTIONS:

**Be sure to make a photocopy of the form on the next page before you fill it out the first time; you need one page for each owner.**

If you have a five-person ownership team, you need to submit five completed Exhibit C1 forms. You may **NOT** submit a list of names; each owner must be reported with a full page of information (**do not attach list—use form provided**).

CHS-LA seeks to identify the owners of this enrolling entity/business. Medicaid requires that an enrolling entity/business fully disclose **ALL** persons and entities that have an ownership interest (either separately or in combination) of 5% or more of this enrolling entity/business. Owners are individuals and organizations having direct, indirect, or controlling ownership interest in this disclosing entity/business. Direct ownership is defined as the possession of stock, equity in capital, or any interest in the profits of this disclosing entity/business.

Indirect ownership is defined as an ownership interest in an entity/business that has direct or indirect ownership in this disclosing entity/business.

Controlling interest is defined as having operational direction or management or the ability and authorization:

- a. To amend or change the corporate identity.
- b. To nominate or name members of the board, directors, or trustees
- c. To amend or change the bylaws, constitution, or other operating or management direction
- d. To control the sale of any or all of the assets or property upon dissolution of the entity/business.
- e. To dissolve or transfer this disclosing entity/business to new ownership or control.
- f. Et cetera.

Owners may also be individuals associated with the enrolling entity/business:

- a. Whose personal assets are used to satisfy the entity/business creditors.
- b. Who join together to carry on an entity/business and expect to share in the profits and losses of the entity/business.
- c. Who report their share of profits and losses of the entity/business on their own personal tax returns.
- d. Who own corporate stock.
- e. Who are policy makers.
- f. Who have veto powers.
- g. Who have voting power.
- h. Who have any other responsibilities similar to the ones described above.

Ownership might be implied by titles like the following:

- |                 |                |
|-----------------|----------------|
| a. Founder      | d. Owner       |
| b. Incorporator | e. Shareholder |
| c. Member       |                |

**This list is not all-inclusive, and other titles that imply or assume similar powers or responsibilities may apply.**

## **EXHIBIT C-1**

### **Information on Each Owner**

Under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of each person, entity or business with an ownership or control interest in the disclosing entity. (*See Federal Regulations 42 CFR § 455.104(a) (1), (2)*). A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether any person, entity or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling. (*See Federal Regulations 42 CFR § 455.104(a)(2)*). Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the provider/ disclosing entity also has an ownership or control interest.

#### **42 C.F.R. Sec. 455.101 Definitions.**

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);(b) Any Medicare intermediary or carrier; and (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Title XVIII of the Social Security Act, Medicare program [42 U.S.C. 1395 et seq.].

Title XIX of the Social Security Act, Medicaid program [42 U.S.C. 1396 et seq.].

Title XX of the Social Security Act, Social Services block grant [42 U.S.C. 1397 et seq.].

TITLE V—Maternal and Child Health Services Block Grant

(*See Federal Regulations 42 CFR § 455.104(a) (3)* [http://www.access.gpo.gov/nara/cfr/waisidx\\_01/42cfr455\\_01.html](http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr455_01.html)).

Under Federal Regulations, a provider or disclosing entity must disclose (at any time upon request) to the Medicaid agency whether any person with ownership, any Agent or any managing employee of the provider or disclosing entity has ever had any criminal conviction related to that individual's involvement in Medicaid, Medicare, or Federally-funded healthcare program since the inception of those programs. (*See Federal Regulations (455. 42 CFR § 455.106 (a) (1) and (2)*).

In addition, Louisiana Medicaid policy, including Louisiana's Medical Assistance Programs Integrity Law (MAPIL Louisiana R.S., Title 46, Chapter 3, Part V1-A) and Administrative Rules, (Louisiana Register, Vol. 29, No. 4, April 20, 2003), as well as Louisiana Provider Update January/February 2009 (available at LAMEDICAID.com) requires potential Medicaid providers, including Officers, Trustees, Partners and Boards of Directors, furnish social security numbers.

Copy and complete a separate form for each owner.

The Owner named on this page is (must check ONE box only per page): Individual  Entity/Business

If you are an individual owner, are you also a manager for this entity/business? Yes  No

<b>Individual OWNER</b>		<b>Title/Job Position within this entity/business</b>		<b>Social Security Number (required)</b>	
<b>First Name</b>	<b>Middle Name</b>	<b>Maiden Name</b>	<b>Last Name</b>	-	<b>Hyphenated Last Name (if applicable)</b>
<b>Current Address of Owner</b>					
<b>City</b>					
<b>State</b>	<b>Email Address</b>				
<b>Zip Code</b>	<b>Telephone Number</b>			<b>Date of Birth (required)</b>	
	-	-		/	/
<b>Entity/Business OWNER</b>					
<b>Entity/Business Name</b>		<b>DBA Name</b>		<b>Tax ID Number (required)</b>	
<b>Current Address of Owner</b>					
<b>City</b>					
<b>State</b>	<b>Email Address</b>				
<b>Zip Code</b>	<b>Telephone Number</b>				

**If the owner named above is an individual:**

A. Is this owner a U.S. citizen? Yes  No

If you answered No above, attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States. For assistance, contact the United States Citizenship and Immigration Services (USCIS) at 1-800-375-5283, or visit the website at [www.uscis.gov](http://www.uscis.gov). List the country(s) of the Owner's citizenship below:

1.	2.	3.
----	----	----

B. Are any owners with direct, indirect, or controlling interest, managing employees, or subcontractors identified for this entity/business related to one another as spouse, parent, child, or sibling? Yes  No

If yes, list all individuals and how they are related below:

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Has the owner named above ever:

C. Been convicted of a felony or convicted of any criminal offense under this name or any other name in any state or U.S. Territory, regardless of a post trial motion, a plea of guilty or nolo contendere or participation in a First Offense pardon program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Had any disciplinary action taken against any professional license or certification held in any state or U.S. Territory, including disciplinary action, board consent order, suspension, revocation, voluntary surrender of a license or certification?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. Been denied enrollment, suspended, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory, or employed by a corporation, entity/business, or professional association that has ever been denied enrollment, suspended, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory? If yes, attach documents (notice of rejection, suspension, exclusion) with an explanation providing details, including date and state in which action occurred, for all individuals/entities/businesses involved. Reinstatement letter required.	<input type="checkbox"/> Yes <input type="checkbox"/> No
F. Used or been known by any other name including married, maiden, hyphenated, alias, or Doing Business As (DBA) name(s)? If yes, enter name(s) below:	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>DBA Name:</b>			<b>DBA Name:</b>	
<b>First Name</b>	<b>Middle Name</b>	<b>Maiden Name</b>	<b>Last Name</b>	- <b>Hyphenated Last Name (if applicable)</b>
<b>First Name</b>	<b>Middle Name</b>	<b>Maiden Name</b>	<b>Last Name</b>	- <b>Hyphenated Last Name (if applicable)</b>
<b>G. Does this owner have ownership or controlling interest in any other entity participating in a Federal/State Funded healthcare program?</b> <b>If yes, in the chart below, provide the appropriate names and TAX ID or NPI for the entity/business.</b>				<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Plan</b>	<b>Provider Name and Doing Business (DBA) Name</b>		<b>Tax ID or NPI</b>	
<input type="checkbox"/> Medicaid	Name		Tax ID #	
	DBA Name		NPI #	
<input type="checkbox"/> Medicare	Name		Tax ID #	
	DBA Name		NPI #	
<input type="checkbox"/> Other Federal/State Funded Healthcare Program	Name		Tax ID #	
	DBA Name		NPI #	
<input type="checkbox"/> Other Federal/State Funded Healthcare Program	Name		Tax ID #	
	DBA Name		NPI #	
<input type="checkbox"/> Other Federal/State Funded Healthcare Program	Name		Tax ID #	
	DBA Name		NPI #	
<b>H. Does this owner reside out-of-state (not in Louisiana?)</b>				<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes, has this out-of-state owner been issued any Medicaid or Medicare provider numbers by the domicile state?</b>				<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes, please provide the Domicile State name and Provider Numbers.</b>				
Domicile State:		Medicaid Provider Number:	Medicare Provider Number:	

Shared Savings (CCN-S) Contract Checklist for Providers	Item Include		Contract Reference
	YES	NO	
Subcontracts shall not contain terms for reimbursement at rates that are less than the published Medicaid fee-for-service rate in effect on the date of service unless a subcontractor-initiated request has been submitted to and approved by DHH. <b>Note:</b> the CCN shall not propose to subcontractors reimbursement rates that are less than the published Medicaid fee-for-service rate.	X		
Contain language that the subcontractor shall adhere to all requirements set forth for CCN subcontractors in the contract between DHH and CCN and department issued <b>Guides</b> ; and either physically incorporating these documents as appendices to the subcontract or include language in the subcontract that the CCN shall furnish these documents to the provider upon request.	X		
Include a signature page which contains a CCN and provider name which are typed or legibly written, provider company with titles, and dated signature of all appropriate parties; (applicable for renewals as well). All subcontracts must be in writing and signed by the CCN and subcontractor.	X		
Specify the effective dates of the subcontract agreement.	X		
Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	X		
Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties, however the CCN may provide amendments by written notification through the CCN bulletin board, if mutually agreed to in terms of the subcontract and with prior notice to DHH. Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract; however the CCN may provide amendments by written notification through CCN bulletins, if mutually agreed to in terms of the contract and with prior notice to DHH.	X		
Specify that the CCN and subcontractor recognize that in the event of termination of the contract between the CCN and DHH for any of the reasons described in the contract, the CCN shall immediately make available, to DHH, or its designated representative, in a usable form, any and all records, whether medical or financial, related to the CCN's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to DHH.	X		
Assure the subcontractor shall not, without prior approval of the CCN, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the CCN.	X		
Require that if any requirement in the subcontract is determined by DHH to conflict with the subcontract between DHH and the CCN, such requirement shall be null and void and all other provisions shall remain in full force and effect.	X		
Identify the population covered by the subcontract.	X		

Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor shall provide these services to members through the last day that the subcontract is in effect. All final Medicaid benefit determinations are within the sole and exclusive authority of DHH or its designee.	X		
Specify that the subcontractor may not refuse to provide medically necessary or core preventive benefits and services to CCN members specified under the contract between DHH and the CCN for non-medical reasons (except those services allowable under federal law for religious or moral objections).	X		
Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the CCN.	X		
Specify the amount, duration and scope of core benefits and services as specified in the Louisiana Medicaid State Plan that are provided by the subcontractor, including all specific requirements outlined in the RFP and CCN Policy and Procedures Guide.	X		
Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	X		
Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 CFR §§ 493.1 and 493.3, and any other federal requirements.	X		
Specify that the provider may not refuse to provide covered medically necessary or covered preventative services to members for non-medical reasons. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship.	X		
Include a provision which states the subcontractor is not permitted to encourage or suggest, in any way, that members be placed in state custody in order to receive medical or specialized behavioral health services covered by DHH.	X		
Require that an adequate record system be maintained for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to CCN members pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between DHH and the CCN). CCN members and their representatives shall be given access to and can request copies of the members' medical records, to the extent and in the manner provided by LRS 40:1299.96 and 45 CFR 164.524 as amended and subject to reasonable charges.	X		
Include medical record requirements as specified in the contract between DHH and the CCN.	X		

Require that any and all member records including but not limited to administrative, financial, and medical be retained (whether electronic or paper) for a period of six (6) years after the last payment was made for services provided to a member and retained further if the records are under review, audit, or related to any matter in litigation until the review, audit, or litigation is complete. The exception to this requirement shall include records pertaining to once-in-a-lifetime events such as but not limited to appendectomy and amputations etc., which must be retained indefinitely and may not be destroyed. This requirement pertains to the retention of records for Medicaid purposes only; other state or federal rules may require longer retention periods. Current State law (La. R.S. 40:1299.96) requires physicians to retain their records for at least six (6) years. These minimum record keeping periods commence from the last date of treatment. After these minimum record-keeping periods, state law allows for the destruction of records. Said records shall be made available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of an authorized representative of DHH.	X		
Provide that DHH, U.S. Department of Health and Human Services (HHS), CMS, Office of Inspector General Comptroller, State Legislative Auditor's Office, and the Louisiana Attorney General's Office shall have the right to evaluate through audit, inspection, or other means, whether announced or unannounced, any records pertinent to the contract between DHH and the CCN, including quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and practitioner claims submitted to the CCN. Such evaluation, when performed, shall be performed with the cooperation of the CCN. Upon request, the CCN shall assist in such reviews.	X		
Require the subcontractor comply and submit to the CCN disclosure of information in accordance with the requirement specified in 42 CFR §455, Subpart B.	X		
Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the CCN and/or DHH or its designee.	X		
Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the CCN/subcontractor practices and/or the standards established by DHH or its designee.	X		
Require that the subcontractor comply with any corrective action plan initiated by the CCN and/or required by DHH.	X		
Specify any monetary penalties, sanctions or reductions in payment that the CCN may assess on the provider for specific failures to comply with subcontractual and/or credentialing requirements. This shall include, but may not be limited to a provider's failure or refusal to respond to the CCN's request for information, the request to provide medical records, credentialing information, etc.; at the CCN's discretion or a directive by DHH, the CCN shall impose at a minimum, financial consequences against the provider as appropriate.	X		
Provide for submission of all reports and clinical information required by the CCN for reporting purposes such as HEDIS, AHRQ, and EPSDT.	X		
Require safeguarding of information about CCN members according to applicable state and federal laws and regulations and as described in contract between DHH and the CCN.	X		
Provide the name and address of the official payee to whom payment shall be made.	X		
Make full disclosure of the method and amount of compensation or other consideration to be received from the CCN.	X		
Provide for prompt submission of complete and accurate claims information needed to make payment.	X		
Provide that subcontractors must submit all clean claims for payment no later than twelve (12) months from the date of service.	X		

Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold DHH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between DHH and the CCN, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between DHH and the CCN in its entirety in the subcontractor's agreement or by use of other language developed by the CCN and approved by DHH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by DHH.	X		
Require the subcontractor to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the CCN's members and the CCN under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the CCN with written verification of the existence of such coverage.	X		
Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services under the CCN Program.	X		
Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective. In the event that changes in the subcontract as a result of revisions and applicable federal or state law materially affect the position of either party, the CCN and subcontractor agree to negotiate such further amendments as may be necessary to correct any inequities.	X		
Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract; however, the CCN may provide amendments by written notification through a CCN bulletins, if mutually agreed to in terms of the subcontract and with prior notice to DHH.	X		
Specify that the CCN and subcontractor recognize that in the event of termination of the contract between the CCN and DHH for any of the reasons described in contract between the CCN and DHH, the CCN shall immediately make available, to DHH, or its designated representative, in a usable form, any and all records, whether medical or financial, related to the CCN's and its subcontractor's activities undertaken pursuant to the subcontract. The provision of such records shall be at no expense to DHH.	X		
Provide that the CCN and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the CCN member.	X		
Include a conflict of interest clause as stated in the contract between DHH and the CCN.	X		
Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined in CCN-S Policy and Procedures Guide and Quality Companion Guide. The QAPI and UM requirements shall be included as part of the subcontract between the CCN and the subcontractor.	X		
Provide that all subcontractors shall give CCN immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the CCN.	X		
Contain no provision which provides incentives, monetary or otherwise, for the withholding of medically necessary care.	X		
Specify that the subcontractor shall not assign any of its duties and/or responsibilities as required in the contract between DHH and the CCN without the prior written consent of the CCN.	X		

Specify that the CCN shall not prohibit or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient {1932(b)(3)(D), 42 CFR §438.102(a)(1)(i),(ii),(iii) and (iv)}: a) for the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; b) for any information the enrollee needs in order to decide among all relevant treatment options; c) for the risks, benefits, and consequences of treatment or non-treatment; and d) for the enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.	X		
Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	X		
Contain no provision which restricts a subcontractor from subcontracting with another CCN or other managed care entity.	X		
Provide that all records originated or prepared in connection with the subcontractor's performance of its obligations under the subcontract, including but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by the subcontractor in accordance with the terms and conditions of the contract between DHH and the CCN. The subcontract must further provide that the subcontractor agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of members relating to the delivery of care or service under the contract between DHH and the CCN and as further required by DHH, for a period of six (6) years from the expiration date of the contract between DHH and the CCN, including any contract extension(s). If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the six (6) year period, whichever is later. If the subcontractor stores records on microfilm or microfiche or other electronic means, the subcontractor must agree to produce, at its expense, legible hard copy records upon the request of state or federal authorities, within twenty-one (21) calendar days of the request.	X		
State that in accordance with 42 CFR §438.210(e) compensation to the CCN or individuals that conduct utilization management activities is not structured so as to provide incentives for the individual or CCN to deny, limit, or discontinue medically necessary services to any member.	X		
Provide that subcontractors, as applicable, register all births through LEERS (Louisiana Electronic Event Registration System) administered by DHH/Vital Records Registry.	X		
Provide that PCP's subcontract specify the maximum number of linkages the CCN may link to the PCP. The subcontract shall also stipulate that by signing the subcontract the PCP confirms that the PCP's total number of Medicaid members for the CCN Program will not exceed 2,500 lives.	X		
CCNs are prohibited from making payments to subcontractors for the provision of medical assistance for health care-acquired conditions and other provider-preventable conditions as may be identified by DHH.	X		



# Louisiana Medicaid Electronic Health Records (EHR) Incentive Program

## Money Available for Building, Enhancing Electronic Health Records Systems

The **Louisiana Medicaid Electronic Health Records (EHR) Incentive Program** will provide payments to eligible medical professionals and hospitals for adopting, implementing or upgrading certified EHR technology during their first year of participation and demonstrating meaningful use of EHR in subsequent years.

Through electronic health records, providers can enhance care coordination and patient safety, reduce their paperwork, improve efficiency and establish faster, more effective lines of communication across providers, payers and state lines.

### Program highlights:

- ▶ Eligible providers and hospitals can register to participate in Louisiana's Medicaid EHR Incentive Program beginning in **January 2011**.
- ▶ An eligible provider can receive up to \$63,750 over six years under the program. Providers' EHR incentive payments are made by the state based on the calendar year. To receive the maximum payment, providers must enroll by 2016.
- ▶ An eligible hospital may begin receiving EHR incentive payments starting in FY 2011 through FY 2016, but payments will decrease for hospitals that start receiving payments in 2014 or later. Hospital payments are based on many factors, beginning with a \$2 million base payment. Hospital payments are made by the state based on the federal fiscal year.

### What Should Providers/Hospitals Do to Get Started?

1. **Visit the eligibility page at [www.cms.gov](http://www.cms.gov) to determine if you meet the requirements for participation.** Eligible providers include physicians (primarily doctors of medicine or osteopathy), nurse practitioners, certified nurse-midwives, dentists, and physician assistants who practice in a federally qualified health center or rural health clinic led by a physician assistant. Eligible hospitals include children's hospitals and acute care hospitals.
2. **Make sure you have enrollment records in the appropriate systems:** National Provider Identifier; National Plan and Provider Enumeration System; and Provider Enrollment, Chain and Enrollment System.
3. **Get certified to use EHR technology.** Contact the Louisiana Health Information Technology Resource Center, provided through the Louisiana Health Care Quality Forum, at [rec@lhcf.org](mailto:rec@lhcf.org) to inquire about training and certification.

For more information about how to participate in this program and receive payments, contact Tyler Carruth, Louisiana Medicaid EHR Incentive Payment Program, at 225-342-4810 or [tyler.carruth@la.gov](mailto:tyler.carruth@la.gov), or visit [www.lamedicaid.com](http://www.lamedicaid.com).



**DEPARTMENT OF HEALTH  
AND HOSPITALS**  
*Medicaid*

# Authorization to Disclose Health Information



Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Record #: \_\_\_\_\_ Client SS #: \_\_\_\_\_

I \_\_\_\_\_ hereby authorize  
*(Client or Personal Representative)*

\_\_\_\_\_ to disclose specific health information  
*(Name of Provider/Plan/Agency)*

from the records of the above named client to: \_\_\_\_\_  
*(Recipient Name/Address/Phone/Fax)*

for the specific purpose(s): \_\_\_\_\_

Specific information to be disclosed: \_\_\_\_\_

I understand that this authorization will expire on the following date, event, or condition: \_\_\_\_\_

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that refusal to sign this authorization will not condition or limit my access to treatment, payment, enrollment or eligibility for benefits available to me.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I further understand that I may request a copy of this signed authorization.

\_\_\_\_\_  
*(Signature of Client)*                      *(Date)*                      *(Witness-If Required)*

\_\_\_\_\_  
*(Signature of Personal Representative)*                      *(Date)*                      *(Personal Representative Relationship/Authority)*

NOTE: This Authorization was revoked on \_\_\_\_\_  
*(Date)*                      *(Signature of Staff)*

### Revocation Section

I do hereby request that this authorization to disclose health information of \_\_\_\_\_  
*(Name of Client)*

signed by \_\_\_\_\_ on \_\_\_\_\_  
*(Enter Name of Person Who Signed Authorization)*                      *(Enter Date of Signature)*

be rescinded, effective \_\_\_\_\_. I understand that any action taken on this authorization prior to the  
*(Date)*

rescinded date is legal and binding.

\_\_\_\_\_  
*(Signature of Client)*                      *(Date)*                      *(Signature of Witness)*                      *(Date)*

\_\_\_\_\_  
*(Signature of Personal Representative)*                      *(Date)*                      *(Personal Representative Relationship/Authority)*

### Verbal Revocation Section

I do hereby attest to the verbal request for revocation of this authorization by \_\_\_\_\_  
*(Name of Client or Personal Representative)*

on \_\_\_\_\_. The client or his personal representative has been informed that any  
*(Date)*

action taken on this authorization prior to the rescinded date is legal and binding.

\_\_\_\_\_  
*(Signature of Staff)*                      *(Date)*                      *(Signature of Witness)*                      *(Date)*

# Medical Home Communication Form



Date:	Referral #:
Patient Name:	Patient Medicaid ID:
Medical Home Name:	Specialist Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:
<b>To Be Completed by Medical Home:</b>	
Brief History of Present Illness:	
Pertinent Physical Findings:	
X-Ray and Lab Findings:	
Current Medications:	
Reason for Consultation:	
Requested Disposition: Consultation and:	
<input type="checkbox"/>	Please send written report
<input type="checkbox"/>	Assume management of this particular illness
<input type="checkbox"/>	Return Patient with recommendations for management
<input type="checkbox"/>	Assume future comprehensive care for patient
<input type="checkbox"/>	Other:
<b>To Be Completed by Specialist and Returned to Medical Home</b>	
Assessment:	
Treatment Plan and Follow-up Instructions:	
Recommendation:	
Specialist Signature:	
Date:	

**WIC REFERRAL FORM**

**PL103-448, S204(e) requires States using managed care arrangements to serve their Medicaid beneficiaries to coordinate their WIC and Medicaid Programs. This coordination should include the referral of potentially eligible women, infants, and children and the provision of medical information to the WIC Program. To help facilitate the information exchange process, please complete this form and send it to the address listed below. Thank you for your cooperation.**

**Name of Person being referred:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

The following classifications describe the population served by the WIC Program. Please check the category that most appropriately describes the person being referred:

Pregnant Women

Woman who is breast feeding her infant(s) up to one year postpartum

Woman who is non-breast feeding up to six months postpartum

Infant (age 0-1)

Child under age 5

States may consider using this space to either include specific medical information or to indicate that such information can be provided if requested by the WIC Program.

**Provider's Name:** \_\_\_\_\_

**Provider's Phone:** \_\_\_\_\_

I, the undersigned, give permission for my provider to give the WIC Program any requires medical information

\_\_\_\_\_  
(Signature of the patient being referred or, in the case of children and infants signature and printed name of the parent/guardian)

**Send completed form to:**

WIC PROGRAM CONTACT  
ADDRESS  
PHONE NUMBER

## CCN-S Population Categories

Mandatory Populations	Voluntary Populations	Excluded Populations
Low Income Families with Children- both Children under 19 and Parents	SSI Children under 19	Hospice recipients
TANF Families- both Children under 19 and Parents	Foster Care Children	Nursing Facility Residents
Regular Medically Needy Program Members- both Children under 19 and Parents	Children in Out-of-Home Placements	ICF/DD Facility Residents
CHAMP Children under 19	Children Receiving Foster Care or Adoption Assistance	Dual Eligibles
LaCHIP Phase I-IV Children under 19	Children receiving services through family-centered, community-based, coordinated care system	Tuberculosis Infected Individual Program Members
Deemed Eligible Infants	Children enrolled through Family Opportunity Act Medicaid Buy-in Program	1915 (c) Home & Community-based Waiver Program Members
Youth Aging Out of Foster Care ( ages 19 to 21)	Native Americans	Chisholm Class Members
Pregnant Women Category Members		PACE Program Members
Breast and Cervical Cancer Program Members		Spend-down Medically Needy Program Members
Aged, Blind & Disabled adults, including SSI Program Members		Emergency-Services Only Recipients
Extended Medicaid Program Members		Continued Medicaid Program Members
		LaCHIP Affordable Plan Program (LaCHIP Phase V) Members
		Family Planning Waiver Members
		LaHIPP Program Members