

## APPENDICES



### PREPAID COORDINATED CARE NETWORKS

LOUISIANA MEDICAID COORDINATED CARE PROGRAM  
BUREAU OF HEALTH SERVICES FINANCING  
DEPARTMENT OF HEALTH AND HOSPITALS

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

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

**Release Date: 4/11/2011**

ADOBE/WORD/EXCEL versions of appendices are available at:

**<http://new.dhh.louisiana.gov/index.cfm/page/271>**

**LIST OF APPENDICES TO RFP**

Appendix A – Certification Statement ..... 4

Appendix B – DHH Standard Contract Form (CF-1) ..... 6

Appendix C – HIPAA Business Associate Agreement ..... 11

Appendix D – Map of Parishes Within Each GSA ..... 17

Appendix E – Reserved ..... 19

Appendix F – Louisiana Standardized Credentialing Application Form ..... 20

Appendix G – Rates with Actuarial Rate Certification Letter ..... 21

Appendix H – MLR (Medical Loss Ratio) Calculation Methodology ..... 63

Appendix I – Louisiana Medicaid State Plan Services ..... 73

Appendix J – CCN Performance Measures ..... 75

Appendix K – WIC Referral Form ..... 79

Appendix L – Hysterectomy Consent Form ..... 81

Appendix M – Sterilization Consent Form ..... 83

Appendix N – Abortion Consent Form ..... 86

Appendix O – CCN Subcontract Requirements ..... 89

Appendix P – CCN Data Use Agreement ..... 98

Appendix Q – Requirements for CCN-P Physician Incentive Plans ..... 102

Appendix R – Provider’s Bill of Rights ..... 107

Appendix S – Request for Newborn ID Manual ..... 109

Appendix T – CCN Request for Member Disenrollment ..... 127

Appendix U – Guidelines for Member Disenrollment ..... 129

Appendix V – Fiscal Intermediary (FI) Payment Schedule ..... 132

Appendix W – DHH Marketing and Member Education Materials Approval Form ..... 134

Appendix X – DHH Event Submission Form ..... 136

Appendix Y – Reserved ..... 138

Appendix Z – DHH Marketing Complaint Form ..... 139

Appendix AA – Member’s and Potential Member’s Bill of Rights ..... 141

Appendix BB – Marketing Plan Monthly Report ..... 144

Appendix CC – Grievance and Appeal and Fair Hearing Log Report ..... 145

## CCN-P REQUEST FOR PROPOSALS

Appendix DD – Performance Improvement Projects .....	152
Appendix EE – Coordination of CCN Fraud and Abuse Complaints and Referrals ...	154
Appendix FF – CCN Provider and Subcontractor Listing .....	157
Appendix GG – CCN Disenrollment Report .....	159
Appendix HH – EPSDT Reporting .....	160
Appendix II – Model Attestation Letter for Reports .....	168
Appendix JJ – Transition Period Requirements .....	170
Appendix KK – CCN-P Proposal Submission and Evaluation Documents .....	179
Appendix LL – Louisiana Rural Parishes Map .....	245
Appendix MM – Attestation of Provider Network Submission .....	247
Appendix NN – Person First Policy .....	249
Appendix OO – Provider Incentive Payments Template .....	253
Appendix PP – Reference Questionnaire .....	259
Appendix QQ – CCN-OPH MOU.....	263

# **Appendix A**

## **Certification Statement**

**CCN-P REQUEST FOR PROPOSALS  
CNC-P PROPOSAL CERTIFICATION STATEMENT  
RFP # 305PUR-DHHRFP-CCN-P-MVA**

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

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

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

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

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

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

Authorized Signature: \_\_\_\_\_

Typed or Printed Name: \_\_\_\_\_

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

Company Name: \_\_\_\_\_

## **Appendix B**

### **DHH Standard Contract Form CF-1**

**CCN-P REQUEST FOR PROPOSALS**

DHH - CF - 1  
Revised: 2010-08

**CONTRACT BETWEEN STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS**

**CFMS:** \_\_\_\_\_

**DHH:** \_\_\_\_\_

**Medical Vendor Administration**

**Agency # 305**

**AND**

**FOR**

Personal Services  Professional Services  Consulting Services  Social Services

1) <b>Contractor (Legal Name if Corporation)</b> _____	5) <b>Federal Employer Tax ID# or Social Security # (Must be 11 Digits)</b> _____						
2) <b>Street Address</b> _____	6) <b>Parish(es) Served</b> _____						
<table style="width:100%; border: none;"> <tr> <td style="width:33%;"><b>City</b></td> <td style="width:33%;"><b>State</b></td> <td style="width:33%;"><b>Zip Code</b></td> </tr> <tr> <td>_____</td> <td>LA</td> <td>_____</td> </tr> </table>	<b>City</b>	<b>State</b>	<b>Zip Code</b>	_____	LA	_____	7) <b>License or Certification #</b> _____
<b>City</b>	<b>State</b>	<b>Zip Code</b>					
_____	LA	_____					
3) <b>Telephone Number</b> _____	8) <b>Contractor Status</b>  Subrecipient: <input type="checkbox"/> Yes <input type="checkbox"/> No Corporation: <input type="checkbox"/> Yes <input type="checkbox"/> No For Profit: <input type="checkbox"/> Yes <input type="checkbox"/> No Publicly Traded: <input type="checkbox"/> Yes <input type="checkbox"/> No						
4) <b>Mailing Address (if different)</b> _____							
<table style="width:100%; border: none;"> <tr> <td style="width:33%;"><b>City</b></td> <td style="width:33%;"><b>State</b></td> <td style="width:33%;"><b>Zip Code</b></td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>	<b>City</b>	<b>State</b>	<b>Zip Code</b>	_____	_____	_____	8a) <b>CFDA#(Federal Grant #)</b> _____
<b>City</b>	<b>State</b>	<b>Zip Code</b>					
_____	_____	_____					

9) **Brief Description Of Services To Be Provided:**  
 Contractor shall provide a broad range of services necessary for the delivery of healthcare services to Medicaid enrollees participating in the Medicaid Coordinated Care Network (CCN) Program, utilizing the most cost effective manner. Such services include developing and maintaining an adequate provider network, access standards, utilization management, quality management, prior authorization, provider monitoring, member and provider services, primary care management, fraud and abuse monitoring and compliance, case management, chronic care management and account management. This contract includes such duties as 24/7 access to a health care professional, service authorization, provider payments, claims management, marketing and member education. See Statement of Work.

10) <b>Effective Date</b> 01-01-2012	11) <b>Termination Date</b> 12-31-2014
--------------------------------------	--

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

13) **Maximum Contract Amount** \_\_\_\_\_

14) **Terms of Payment**  
 If progress and/or completion of services are provided to the satisfaction of the initiating Office/Facility, payments are to be made as follows: DHH shall make monthly capitated payments for each member enrolled into the CCN. The CCN shall agree to accept, as payment in full, the actuarially sound rate and maternity kick payment established by DHH pursuant to the contract, and shall not seek additional payment from a member, or DHH, for any unpaid cost. DHH reserves the right to defer remittance of the PMPM payment for June until the first Medicaid Management Information System (MMIS) payment cycle in July to comply with state fiscal policies and procedure

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

<b>PAYMENT WILL BE MADE ONLY UPON APPROVAL OF:</b>	<b>First Name</b>	<b>Last Name</b>
	_____	_____
	<b>Title</b>	<b>Phone Number</b>
	_____	_____

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

## CCN-P REQUEST FOR PROPOSALS

Revised: 2010-08

DHH CF-1 (Page 2)

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

1. Contractor hereby agrees to adhere as applicable to the mandates dictated by Titles VI and VII of the Civil Rights Act of 1964, as amended; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; Americans with Disabilities Act of 1990 as amended; the Rehabilitation Act of 1973 as amended; Sec. 202 of Executive Order 11246 as amended, and all applicable requirements imposed by or pursuant to the regulations of the U. S. Department of Health and Human Services. Contractor agrees not to discriminate in the rendering of services to and/or employment of individuals because of race, color, religion, sex, age, national origin, handicap, political beliefs, disabled veteran, veteran status, or any other non-merit factor.
2. Contractor shall abide by the laws and regulations concerning confidentiality which safeguard information and the patient/client confidentiality. Information obtained shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (The Contractor shall establish, subject to review and approval of the Department, confidentiality rules and facility access procedures.)
3. The State Legislative Auditor, Office of the Governor, Division of Administration, and Department Auditors or those designated by the Department shall have the option of auditing all accounts pertaining to this contract during the contract and for a three year period following final payment. Contractor grants to the State of Louisiana, through the Office of the Legislative Auditor, Department of Health and Hospitals, and Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours.

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

4. Contractor agrees to retain all books, records and other documents relevant to the contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 74:53 (b) whichever is longer. Contractor shall make available to the Department such records within thirty (30) days of the Department's written request and shall deliver such records to the Department's central office in Baton Rouge, Louisiana, all without expense to the Department. Contractor shall allow the Department to inspect, audit or copy records at the contractor's site, without expense to the Department.
5. Contractor shall not assign any interest in this contract and shall not transfer any interest in the same (whether by assignment or novation), without written consent of the Department thereto, provided, however, that claims for money due or to become due to Contractor from the Department under this contract may be assigned to a bank, trust company or other financial institution without advanced approval. Notice of any such assignment or transfer shall be promptly furnished to the Department and the Division of Administration, Office of Contractual Review.
6. Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this contract shall be Contractor's. The contractor assumes responsibility for its personnel providing services hereunder and shall make all deductions for withholding taxes, and contributions for unemployment compensation funds.
7. Contractor shall obtain and maintain during the contract term all necessary insurance including automobile insurance, workers' compensation insurance, and general liability insurance. The required insurances shall protect the Contractor, the Department of Health and Hospitals, and the State of Louisiana from all claims related to Contractor's performance of this contract. Certificates of Insurance shall be filed with the Department for approval. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days advance written notice to the Department. Commercial General Liability Insurance shall provide protection during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as claims for property damages, with combined single limits prescribed by the Department.
8. ~~In cases where travel and related expenses are required to be identified separate from the fee for services, such costs shall be in accordance with State Travel Regulations. The contract contains a maximum compensation which shall be inclusive of all charges including fees and travel expenses.~~
9. No funds provided herein shall be used to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition or any election ballot or a proposition or matter having the effect of law being considered by the legislature or any local governing authority. Contracts with individuals shall be exempt from this provision.
10. ~~Should contractor become an employee of the classified or unclassified service of the State of Louisiana during the effective period of the contract, Contractor must notify his/her appointing authority of any existing contract with State of Louisiana and notify the contracting office of any additional state employment. This is applicable only to contracts with individuals.~~

## CCN-P REQUEST FOR PROPOSALS

Revised: 2010-08

DHH CF-1 (Page 3)

11. All non-third party software and source code, records, reports, documents and other material delivered or transmitted to Contractor by State shall remain the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract. All non-third party software and source code, records, reports, documents, or other material related to this contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract.
12. Contractor shall not enter into any subcontract for work or services contemplated under this contract without obtaining prior written approval of the Department. Any subcontracts approved by the Department shall be subject to conditions and provisions as the Department may deem necessary; provided, however, that notwithstanding the foregoing, unless otherwise provided in this contract, such prior written approval shall not be required for the purchase by the contractor of supplies and services which are incidental but necessary for the performance of the work required under this contract. No subcontract shall relieve the Contractor of the responsibility for the performance of contractual obligations described herein.
13. No person and no entity providing services pursuant to this contract on behalf of contractor or any subcontractor is prohibited from providing such services by the provisions of R.S. 1113 as amended in the 2008 Regular Session of the Louisiana Legislature.
14. No claim for services furnished or requested for reimbursement by Contractor, not provided for in this contract, shall be allowed by the Department. In the event the Department determines that certain costs which have been reimbursed to Contractor pursuant to this or previous contracts are not allowable, the Department shall have the right to set off and withhold said amounts from any amount due the Contractor under this contract for costs that are allowable.
15. This contract is subject to and conditioned upon the availability and appropriation of Federal and/or State funds; and no liability or obligation for payment will develop between the parties until the contract has been approved by required authorities of the Department; and, if contract exceeds \$20,000, the Director of the Office of Contractual Review, Division of Administration in accordance with La. R.S. 39:1502..
16. The continuation of this contract is contingent upon the appropriation of funds from the legislature to fulfill the requirements of the contract. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.
17. Any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when reduced to writing, as an amendment duly signed, and approved by required authorities of the Department; and, if contract exceeds \$20,000, approved by the Director of the Office of Contractual Review, Division of Administration. Budget revisions approved by both parties in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.
18. Any contract disputes will be interpreted under applicable Louisiana laws and regulations in Louisiana administrative tribunals or district courts as appropriate.
19. Contractor will warrant all materials, products and/or services produced hereunder will not infringe upon or violate any patent, copyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against DHH, the Department shall promptly notify Contractor in writing and Contractor shall defend such claim in DHH's name, but at Contractor's expense and shall indemnify and hold harmless DHH against any loss, expense or liability arising out of such claim, whether or not such claim is successful. This provision is not applicable to contracts with physicians, psychiatrists, psychologists or other allied health providers solely for medical services.
20. ~~Any equipment purchased under this contract remains the property of the Contractor for the period of this contract and future continuing contracts for the provision of the same services. Contractor must submit vendor invoice with reimbursement request. For the purpose of this contract, equipment is defined as any tangible, durable property having a useful life of at least (1) year and acquisition cost of \$1000.00 or more. The contractor has the responsibility to submit to the Contract Monitor an inventory list of DHH equipment items when acquired under the contract and any additions to the listing as they occur. Contractor will submit an updated, complete inventory list on a quarterly basis to the Contract Monitor. Contractor agrees that upon termination of contracted services, the equipment purchased under this contract reverts to the Department. Contractor agrees to deliver any such equipment to the Department within 30 days of termination of services.~~
21. Contractor agrees to protect, indemnify and hold harmless the State of Louisiana, DHH, from all claims for damages, costs, expenses and attorney fees arising in contract or tort from this contract or from any acts or omissions of Contractor's agents, employees, officers or clients, including premises liability and including any claim based on any theory of strict liability. This provision does not apply to actions or omissions for which LA R.S. 40:1299.39 provides malpractice coverage to the contractor, nor claims related to treatment and performance of evaluations of persons when such persons cause harm to third parties (R.S. 13:5108.1(E)). Further it does not apply to premises liability when the services are being performed on premises owned and operated by DHH.

CCN-P REQUEST FOR PROPOSALS

Revised: 2010-08

DHH CF-1 (Page 4)

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

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

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

[Blank signature box]

**STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS**

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_  
\_\_\_\_\_  
**NAME**  
\_\_\_\_\_  
**TITLE**

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_  
\_\_\_\_\_  
**NAME**  
Secretary, Department of Health and Hospital or Designee  
**TITLE**

[Blank signature box]

**Medical Vendor Administration**

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_  
\_\_\_\_\_  
**NAME**  
\_\_\_\_\_  
**TITLE**

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_  
\_\_\_\_\_  
**NAME**  
\_\_\_\_\_  
**TITLE**

## **Appendix C**

# **HIPAA Business Associate Agreement**

**HIPAA BUSINESS ASSOCIATE AGREEMENT****A. Purpose**

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

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

1. Business Associate means the same as “business associate” in 45 CFR § 160.103.
2. Covered Entity means DHH.
3. Designated Record Set means the same as “designated record set” in 45 CFR § 164.501.
4. Individual means the same as "individual" in 45 CFR § 160.103 and includes a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
5. Privacy Rule means the HIPAA Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 160 and Part 164, Subparts A and E).
6. Protected Health Information (PHI) means the same as the term protected health information in 45 CFR § 160.103, limited to information received by Agency from Covered Entity.
7. Required By Law means the same as "required by law" in 45 CFR § 164.103, and other law applicable to the PHI disclosed pursuant to the Contract.
8. Secretary means the Secretary of the Department of Health and Hospitals or designee.
9. Security Standards shall mean the Security Standards at 45 C.F.R. Part 160 and Part 164, as may be amended.
10. Electronic PHI shall have the same meaning as the term “electronic protected health information” in 45 C.F.R. § 160.103.
11. Security Incident means the attempted or successful unauthorized access, use,

disclosure, modification, or destruction of information or interference with system operations in an information system or its current meaning under 45 C.F.R. § 164.304.

C. Business Associate Provisions

Business Associate agrees to:

1. Not use or disclose PHI other than as permitted or required by the Contract or as required by law.
2. Use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for in the Contract.
3. Mitigate to the extent practicable, any harmful effect known to Business Associate if it uses/discloses PHI in violation of the Contract.
4. Immediately report to Covered Entity any breaches in privacy or security that compromise PHI. Security and/or privacy breaches should be reported to:

Louisiana Department of Health and Hospitals  
Bureau of Legal Services  
Post Office Box 3836  
Baton Rouge, Louisiana 70821  
Phone: (225) 342-1112  
Fax: (225) 342-2232

The Report should include a detailed description of the breach and any measures that have been taken by the Business Associate to mitigate the breach.

DHH may impose liquidated damages of \$300 per day from the date that the Business Associate knew or should have known of any breach in privacy or security that compromises PHI to the date that DHH becomes aware of the breach.

DHH may impose liquidated damages of up to \$25,000 for any breach in privacy or security that compromises PHI.

5. Ensure that any agent/contractor to whom it provides PHI agrees to the same restrictions/conditions that apply to the Business Associate in this Agreement.
6. If the Business Associate has PHI in a designated record set: (1) provide access at Covered Entity's request to PHI to Covered Entity or, as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR § 164.524; (2) make any amendment(s) to PHI in a designated record set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526.
7. Make its internal practices, books, records, and policies/procedures relating to the use/disclosure of PHI received from, or created or received by Business

Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity, to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

8. Document Business Associate disclosures of PHI, other than disclosures back to Covered Entity, and related information as would be required for Covered Entity to respond to a request for an accounting of PHI disclosures in accordance with 45 CFR § 164.528.
9. Provide to Covered Entity or an individual, as designated by Covered Entity, information collected in accordance with Section C.8 of this Agreement, to permit Covered Entity to respond to a request for an accounting of PHI disclosures in accordance with 45 CFR § 164.528.
10. Encrypt all PHI stored on portable devices. Portable devices include all transportable devices that perform computing or data storage, manipulation or transmission including, but not limited to, diskettes, CDs, DVDs, USB flash drives, laptops, PDAs, Blackberrys, cell phones, portable audio/video devices (such as iPODs, and MP3 and MP4 players), and personal organizers.
11. Otherwise, not re-disclose Covered Entity PHI except as permitted by applicable law.
12. Be liable to Covered Entity for any damages, penalties and/or fines assessed against Covered Entity should Covered Entity be found in violation of the HIPAA Privacy Rule due to Business Associate's material breach of this section. Covered Entity is authorized to recoup any and all such damages, penalties and/or fines assessed against Covered Entity by means of withholding and/or offsetting such damages, penalties, and/or fines against any and all sums of money for which Covered Entity may be obligated to the Business Associate under any previous contract and/or this or future contracts. In the event there is no previous contractual relationship between the Business Associate and Covered Entity, the amount to cover such damages, penalties and/or fines shall be due from Business Associate immediately upon notice.

#### D. Permitted Uses and Disclosures by Business Associate

1. Except as limited in the Contract, Business Associate may use PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use would not violate the Privacy Rule if done by Covered Entity or Covered Entity's privacy practices. Unless otherwise permitted in this Agreement, in the Contract or required by law, Business Associate may not disclose/re-disclose PHI except to Covered Entity.
2. Except as limited in this Agreement, Business Associate may use/disclose PHI for internal management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, as needed for Business Associate to provide its services under the Contract.

## CCN-P REQUEST FOR PROPOSALS

### Appendix C

3. Except as limited in this Agreement, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).
4. Business Associate may use PHI to report violations to appropriate Federal or State authorities as permitted by § 164.502(j)(1).

#### E. Covered Entity Provisions

Covered Entity agrees to:

1. Notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
2. Notify Business Associate of any changes in, or revocation of, permission by individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.
3. Notify Business Associate of any restriction to the use/disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use/disclosure of PHI.
4. Not request Business Associate to use/disclose PHI in any manner not permitted under the Privacy Rule if done by Covered Entity.

#### F. Term and Termination

1. The terms of this Agreement shall be effective immediately upon signing of both the Contract and this Agreement, and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is returned to Covered Entity, or, if it is infeasible to return PHI, protections are extended to such PHI in accordance with the termination provisions in this Section.
  - a. Upon its knowledge of a material breach by Business Associate, Covered Entity shall either: Allow Business Associate to cure the breach or end the violation and terminate the Contract if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; or
  - b. Immediately terminate the Contract if Business Associate has breached a material term of this Agreement and cure is not possible; or
  - c. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.
2. Effect of Termination
  - a. Except as provided in paragraph (b) below, upon termination of the Contract, Business Associate shall return all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision also applies to PHI in the possession of Business Associate's

contractors or agents. Business Associate shall retain no copies of the PHI.

- b. If Business Associate determines that returning the PHI is infeasible, Business Associate shall notify Covered Entity of the conditions that make return infeasible. Upon mutual agreement of the parties that return of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return infeasible, for so long as Business Associate maintains such PHI.

G. Security Compliance

Business Associate agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Covered Entity, and will require that its agents and contractors to whom it provides such information do the same. Further, Business Associate agrees to comply with Covered Entity’s security policies and procedures. Business Associate also agrees to provide Covered Entity with access to and information concerning Business Associate’s security and confidentiality policies, processes, and practices that affect electronic PHI provided to or created by Business Associate pursuant to the Agreement upon reasonable request of the Covered Entity. Covered Entity shall determine if Business Associate’s security and confidentiality practices, policies, and processes comply with HIPAA and all regulations promulgated under HIPAA. Additionally, Business Associate will immediately report to Covered Entity any Security Incident of which it becomes aware.

H. Miscellaneous

- 1. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.
- 2. The Parties agree to amend this Agreement as necessary to comply with HIPAA and other applicable law.
- 3. The respective rights and obligations of Business Associate under § F. 3 shall survive the termination of the Contract.
- 4. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

\_\_\_\_\_  
CCN Provider Representative

\_\_\_\_\_  
DHH Representative

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

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

Please print Name: \_\_\_\_\_

Please print Name: \_\_\_\_\_

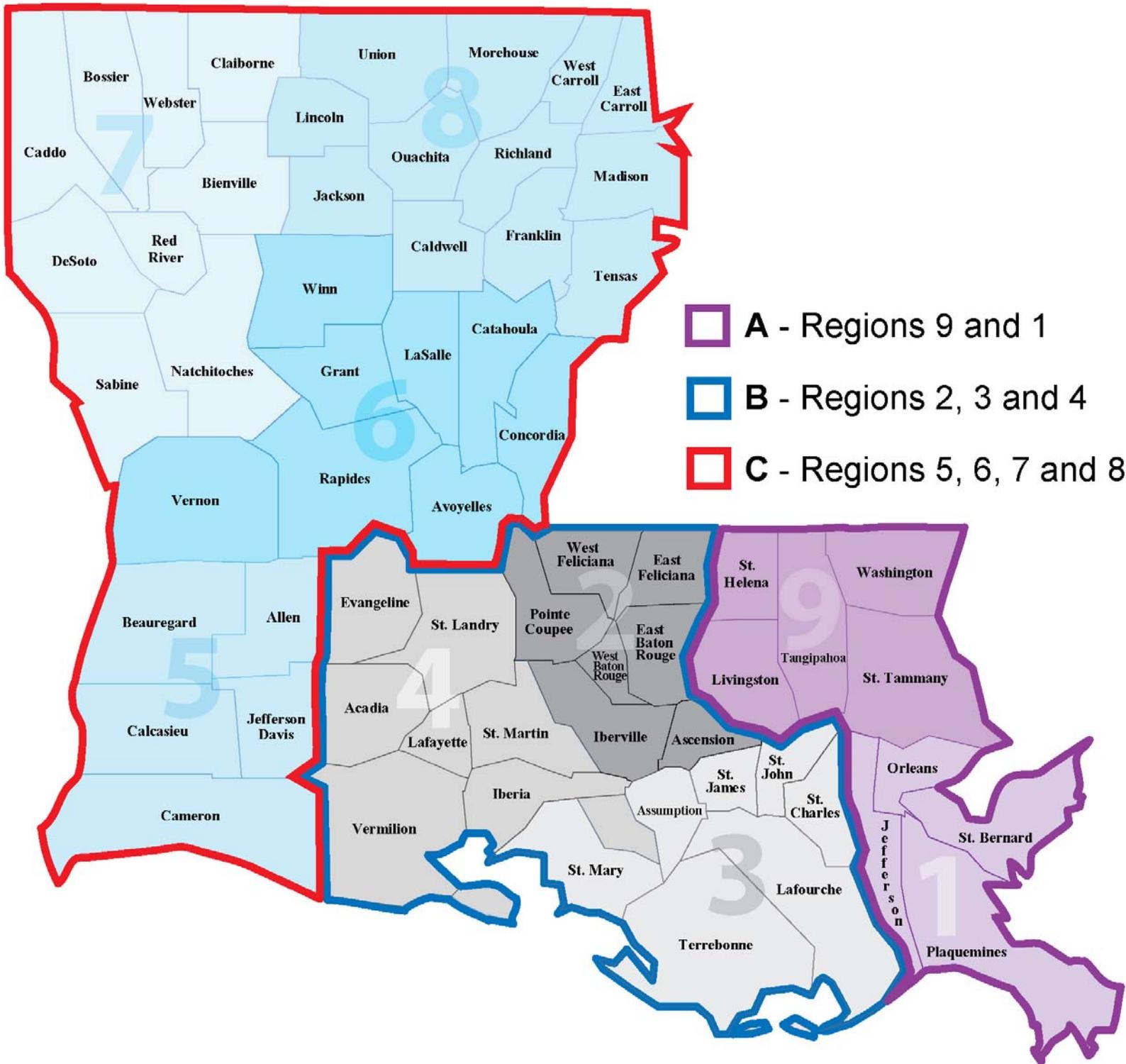
Date: \_\_\_\_\_

Date: \_\_\_\_\_

## **Appendix D**

### **Map of Parishes Within each GSA**

# Proposed CCN Implementation by Regions



# **Appendix E**

**Reserved**

## Appendix F

# Louisiana Standardized Credentialing Application Form

(Form is protected and cannot be included in this document. An Adobe version can be obtained at: <http://new.dhh.louisiana.gov/index.cfm/page/271>)

## **Appendix G**

# **Mercer Rate Certification Letter, Rate Development Methodology and Rates**

## CCN-P REQUEST FOR PROPOSALS

**Nicholas J. Simmons, FIA, FSA, MAAA**

Principal

# MERCER

**Sudha Shenoy, FSA, MAAA, CERA**

Principal

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Ms. Ruth Kennedy  
Deputy Director of Medicaid  
Louisiana Department of Health and Hospitals  
628 North 4th Street  
Baton Rouge, LA 70821

April 8, 2011

**Subject:** Louisiana Coordinated Care Networks – Prepaid (CCN-P) Program Rate Development and Actuarial Certification for Contract Periods ending December 31, 2012

Dear Ruth:

The Louisiana Department of Health and Hospitals (DHH) contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges for Prepaid Coordinated Care Networks (CCN-P) covering contract periods from program startup, which varies by geographical area, through December 31, 2012. The CCN-P program will be implemented in 3 phases and the rates for each phase will be effective through December 31, 2012. The regions implemented in each phase are as follows:

Phase 1 (January 1, 2012 through December 31, 2012)

- New Orleans
- North Shore (formerly known as Mandeville)

Phase 2 (March 1, 2012 through December 31, 2012)

- Baton Rouge
- Thibodaux
- Lafayette

Phase 3 (May 1, 2012 through December 31, 2012)

- Lake Charles
- Alexandria
- Shreveport
- Monroe

# MERCER

Page 2  
April 8, 2011  
Ms. Ruth Kennedy  
Louisiana Department of Health and Hospitals

This letter presents an overview of the methodology used in Mercer's managed care rate development for the purpose of satisfying the requirements of the Centers for Medicare and Medicaid Services (CMS). This rate development process was based on Medicaid fee-for-service (FFS) medical claims and resulted in development of a range of actuarially sound rates for each rate cell. We then worked with DHH to develop a single proposed set of actuarially sound rates for each region and rate cell combination which are attached to and certified within this letter.

## Rate Methodology

### Overview

Capitation rate ranges for the CCN-P program were developed in accordance with rate-setting guidelines established by CMS. One of the key considerations in the rate range development was the base data. Mercer worked with DHH to obtain Medicaid FFS data from State Fiscal Year (SFY) 2009 and SFY 2010. Louisiana's SFY runs from July 1st through June 30th of the following year. Restrictions were applied to the enrollment and FFS claims data so that it matched the populations and benefit package defined in the Contract.

To develop capitation rates, adjustments were applied to the base data consistent with the CMS Capitated Rate-Setting Checklist:

- removal of enrollment and claims during periods of retroactive eligibility (AA.3.4);
- completion factors to account for unpaid claims at the time of the data submission (AA.3.14);
- adjustment to reflect amounts paid outside of the Louisiana Medicaid Management Information System (MMIS), including but not limited to inpatient outlier stays, inpatient and outpatient cost reconciliations, fraud and abuse recoupments (AA.3.0);
- trend factors to forecast the expenditures and utilization to the appropriate contract period (AA.3.10);
- prospective and historic program changes not reflected in the base data (AA.3.1);
- data smoothing (AA.5.0); and
- administration loading, including projected underwriting gain (AA.3.2).

The resulting rate ranges for each individual rate cell were gross of graduate medical education (GME) payments to teaching hospitals provided in the Louisiana Medicaid State Plan. Mercer then worked with DHH to develop a single, actuarially sound, rate, gross of GME for each rate

# MERCER

Page 3  
April 8, 2011  
Ms. Ruth Kennedy  
Louisiana Department of Health and Hospitals

cell. Finally, Mercer developed a GME adjustment for each rate cell designed to reduce the gross rates to net rates consistent with DHH's decision to continue paying exactly the same GME amounts as in the State Plan directly to the teaching hospitals. The resulting net rates are certified actuarially sound later in this letter.

## **Base Data Development**

Mercer was provided with Medicaid FFS enrollment and claims data from SFY09 and SFY10 with runout through August 2010 to develop the capitation rates. Mercer was also provided with supplemental data files containing information on outlier claims paid outside of the MMIS system, fraud and abuse recoupments, GME payments, and Inpatient and Outpatient hospital cost settlements. These payments/recoupments outside of the MMIS system have been added to or subtracted from the base claims data as appropriate so that the relevant cost for the population eligible for enrollment in the CCN-P program is replicated.

Mercer reviewed the data for consistency and reasonableness and determined that the data appears appropriate for the purpose of setting capitation rates for the CCN-P program.

## ***Enrollment Data***

The enrollment file supplied by DHH's fiscal agent provided all enrollment records for each member for each month. Therefore, if a member's eligibility status was retroactively changed, both the old and the new records were present. Most often this occurred because a recipient was retroactively categorized as SSI from Family and Children. In this case, the enrollment file would have included both the SSI enrollment record and the Family and Children record for the same month. Mercer worked with DHH to develop a hierarchy to determine which was the appropriate unique enrollment record to use – typically the SSI record. This treatment is consistent with DHH's proposed policy to recoup the prior capitation payments and re-pay the corrected rates for up to twelve months when status changes retroactively.

## ***Claims Data***

Mercer used fiscal year July 1, 2008 through June 30, 2009 (SFY09) and July 1, 2009 through June 30, 2010 (SFY10) fee-for-service (FFS) data as the data source. The FFS data reflects the actual medical expenses to DHH of providing healthcare coverage for the CCN-P eligible population. The expenses are net Third Party Liability and subrogation. Mercer reviewed the FFS data to ensure it appeared reasonable and appropriate but did not audit the data. Specifically, Mercer reviewed the following issues:

- completeness and consistency of incurred claims over time;

# MERCER

Page 4

April 8, 2011

Ms. Ruth Kennedy

Louisiana Department of Health and Hospitals

- consistency between FFS claims data and DHH published reports;
- all payments outside of the MMIS claims system appeared to be properly accounted for; and
- the data appeared to have been properly restricted to those services and populations to be covered under the CCN-P program.

Adjustments were made to the FFS data to reflect the complete cost of an actuarially equivalent population for the CCN-P contract.

**Outlier Claims for Children Under 6 Years** – DHH makes payments for outlier claims incurred during an Inpatient admission for children under 6 years old outside of the MMIS. Adding outlier claims to the base data resulted in an increase to cost of 2.61% in SFY09 and 2.59% in SFY10. The cost of outlier claims has been reflected in the databook Mercer has prepared for the CCNs.

**Incurred-but-not-Reported Claims Adjustments** – Mercer estimated and adjusted for the remaining liability associated with incurred-but-not-reported claims for SFY09 and SFY10. The overall adjustments for SFY09 and SFY10 using paid claims data through August 2010 were -0.07% and 3.61% respectively.

**Fraud-and-Abuse Recoupments** – Adjustments were made for recoupments due to fraud-and-abuse recoveries. Those adjustments were -0.20% in SFY09 and -0.10% in SFY10.

**Graduate Medical Education (GME) (AA.3.8)** – DHH will be making payments for GME outside of the capitation rates. Therefore, after developing the gross rates, Mercer made adjustments to remove GME payments from the net rates.

**Inpatient, Outpatient Hospital Cost Settlements, and Supplemental Payments to High Medicaid Community Hospitals** – LSU state hospitals and other hospitals receive settlements based on cost reports. Certain “High Medicaid Community Hospitals” also receive supplemental payments that are provided for in the State plan. CCNs are required to pay at least the FFS Medicaid rate when contracting with the hospitals including the impact of cost settlements. Mercer applied adjustments of 3.60% in SFY09 and 1.30% in SFY10 to capture the impact of cost settlements made outside of the MMIS.

**Retroactive eligibility (AA.3.4)** – Individuals will not enroll with a health plan until Medicaid eligible. Even after receiving Medicaid eligibility, it may take 30 days to become enrolled in a health plan. Therefore, enrollment and claims incurred during the retroactive period and those

# MERCER

Page 5  
April 8, 2011  
Ms. Ruth Kennedy  
Louisiana Department of Health and Hospitals

during the first month of Medicaid eligibility have been removed from our calculations. Infants are an exception because they will be covered under the mother's plan from the date of birth.

**Non-covered populations (AA.2.1, AA.2.2)** – In general, the CCN-P program includes individuals classified as SSI, Family and Children, Foster Children and Breast and Cervical Cancer. The following individuals are excluded from participation in the CCN-P program:

- Medicare Dually Eligible Individuals
- Home and Community Based Services Waiver Recipients
- *Chisholm* Class Members
- Individuals Receiving Medicaid Hospice Services
- Individuals Residing in Long Term Care Facilities (Nursing Home, ICF/DD)
- Individuals Receiving Services for Three Months or Less (Medically Needy Spend-down)
- Undocumented Immigrants Eligible for Emergency Services Only
- Enrollees receiving single service (family planning only)
- LaCHIP Affordable Plan

**Non-covered services (AA.2.4)** – The CCN-P rates are based on services covered under the provider agreement. The following services have been excluded in the determination of the capitation rates:

- Services provided through DHH's Early-Steps Program
- Dental Services
- ICF/DD Services
- Hospice
- Personal Care Services (EPSDT and LT-PCS)
- Nursing Facility Services
- Pharmacy
- School-based Individualized Education Plan Services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures

# MERCER

Page 6

April 8, 2011

Ms. Ruth Kennedy

Louisiana Department of Health and Hospitals

- Home and Community-Based Waiver Services
- Specialized Behavioral Health
- Targeted Case Management Services

**Client participation amounts (AA.2.3, AA.3.13)** – Costs associated with “spenddown” and post-eligibility treatment of income are not included in the base data.

**Third-Party Liability (AA.3.6)** – Recoveries associated with Third Party Liability and subrogation have been removed from claims.

**DSH Payments (AA.3.5)** – DSH payments are made outside of the MMIS system and have not been included in the capitation rates. These payments will continue to be made outside of the capitation rates by DHH after implementation of the CCN-P program.

**FQHC and RHC Reimbursement (AA.3.9)** – DHH requires that all health plans reimburse FQHCs and RHCs at the Prospective Payment System (PPS) rate so that cash flows will be improved to these facilities. DHH will perform reconciliation quarterly to ensure that the PPS rate has been paid. In the unlikely event of a shortfall, the plans will pay the amount necessary to bring reimbursements to these facilities up to the PPS rate.

**Co-payments (AA.3.7)** – Co-pays are only applicable to prescription drugs. Since prescription drugs have been carved out of the CCN-P program, no additional adjustment is necessary for co-pays.

**Primary Case Care Management (PCCM) Fee (AA.3.0)** – Historically, Louisiana has paid a PCCM fee for members assigned to a primary care provider under the PCCM program. Since the PCCM fee is not allowed to be included in the capitation rates, Mercer has excluded the PCCM fee by excluding payments associated with procedure code CC001.

## Rate Category Groupings

Rates will vary by the major categories of eligibility. Furthermore, where appropriate, the rates within a particular category of eligibility are subdivided into different age and gender bands to reflect differences in risk due to age and gender and during child bearing ages. In addition, due to the high cost associated with pregnancies, DHH will pay a maternity kickpayment to the plans

# MERCER

Page 7

April 8, 2011

Ms. Ruth Kennedy

Louisiana Department of Health and Hospitals

for each delivery that takes place. The following is a list of the different rate cells for each eligibility category including the maternity kickpayment.

SSI	
<ul style="list-style-type: none"> <li>▪ 0 – 2 Months, Male and Female</li> <li>▪ 3 – 11 Months, Male and Female</li> <li>▪ 1 – 5 Years, Male and Female</li> <li>▪ 6 – 13 Years, Male and Female</li> </ul>	<ul style="list-style-type: none"> <li>▪ 14 – 18 Years, Male and Female</li> <li>▪ 19 – 44 Years, Male and Female</li> <li>▪ 45+ Years, Male and Female</li> </ul>
Family & Children	
<ul style="list-style-type: none"> <li>▪ 0 – 2 Months, Male and Female</li> <li>▪ 3 – 11 Months, Male and Female</li> <li>▪ 1 – 5 Years, Male and Female</li> <li>▪ 6 – 13 Years, Male and Female</li> <li>▪ 14 – 18 Years, Female</li> </ul>	<ul style="list-style-type: none"> <li>▪ 14 – 18 Years, Male</li> <li>▪ 19 – 44 Years, Female</li> <li>▪ 19 – 44 Years, Male</li> <li>▪ 45+ Years, Female</li> <li>▪ 45+ Years, Male</li> </ul>
Foster Care Children, All Ages	Breast and Cervical Cancer, All Ages
Maternity Kickpayment	

## Trend Development

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the expenses of providing health care services in a future period. Mercer reviewed a variety of sources to develop the trend assumptions. These sources included, but were not limited to:

- health care economic indices such as Consumer Price Index for the South-Atlantic region,
- Mercer's regression analysis applied to trends exhibited in the FFS claims data,
- trends in other State Medicaid programs for similar populations, and
- judgment regarding economic outlook balancing a variety of sources.

Mercer developed individual trends for each category of eligibility and service category. Mercer's target trend can be found in the following table.

# MERCER

Page 8

April 8, 2011

Ms. Ruth Kennedy

Louisiana Department of Health and Hospitals

COA Description	COS Description	Utilization	Unit Cost	PMPM Trend
SSI	Inpatient Hospital	1.77%	0.00%	1.77%
SSI	Outpatient Hospital	7.77%	2.54%	10.51%
SSI	Primary Care Physician	3.77%	0.00%	3.77%
SSI	Specialty Care Physician	3.77%	0.00%	3.77%
SSI	FQHC/RHC	3.77%	0.00%	3.77%
SSI	EPSDT	3.77%	0.00%	3.77%
SSI	Certified Nurse Practitioners/Clinical Nurse	3.77%	0.00%	3.77%
SSI	Lab/Radiology	5.51%	0.00%	5.51%
SSI	Home Health	5.51%	0.00%	5.51%
SSI	Emergency Transportation	2.51%	0.00%	2.51%
SSI	Non-Emergency Transportation	2.51%	0.00%	2.51%
SSI	Rehabilitation Services (OT, PT, ST)	5.51%	0.00%	5.51%
SSI	DME	5.51%	0.00%	5.51%
SSI	Clinic	3.77%	0.00%	3.77%
SSI	Family Planning	3.77%	0.00%	3.77%
SSI	Other	5.51%	0.00%	5.51%
SSI	Emergency Room	7.77%	2.54%	10.51%
SSI	Basic Behavioral Health	3.77%	0.00%	3.77%
Family and Children	Inpatient Hospital	1.51%	0.00%	1.51%
Family and Children	Outpatient Hospital	5.51%	2.53%	8.18%
Family and Children	Primary Care Physician	3.51%	0.00%	3.51%
Family and Children	Specialty Care Physician	3.51%	0.00%	3.51%
Family and Children	FQHC/RHC	3.51%	0.00%	3.51%
Family and Children	EPSDT	3.51%	0.00%	3.51%
Family and Children	Certified Nurse Practitioners/Clinical Nurse	3.51%	0.00%	3.51%
Family and Children	Lab/Radiology	5.51%	0.00%	5.51%
Family and Children	Home Health	5.51%	0.00%	5.51%
Family and Children	Emergency Transportation	2.51%	0.00%	2.51%
Family and Children	Non-Emergency Transportation	2.51%	0.00%	2.51%
Family and Children	Rehabilitation Services (OT, PT, ST)	5.51%	0.00%	5.51%
Family and Children	DME	5.51%	0.00%	5.51%
Family and Children	Clinic	3.51%	0.00%	3.51%
Family and Children	Family Planning	3.51%	0.00%	3.51%
Family and Children	Other	5.51%	0.00%	5.51%

# MERCER

Page 9  
 April 8, 2011  
 Ms. Ruth Kennedy  
 Louisiana Department of Health and Hospitals

COA Description	COS Description	Utilization	Unit Cost	PMPM Trend
Family and Children	Emergency Room	5.51%	2.53%	8.18%
Family and Children	Basic Behavioral Health	3.51%	0.00%	3.51%
Foster Care Children	Inpatient Hospital	1.77%	0.00%	1.77%
Foster Care Children	Outpatient Hospital	7.77%	2.55%	10.51%
Foster Care Children	Primary Care Physician	3.77%	0.00%	3.77%
Foster Care Children	Specialty Care Physician	3.77%	0.00%	3.77%
Foster Care Children	FQHC/RHC	3.77%	0.00%	3.77%
Foster Care Children	EPSDT	3.77%	0.00%	3.77%
Foster Care Children	Certified Nurse Practitioners/Clinical Nurse	3.77%	0.00%	3.77%
Foster Care Children	Lab/Radiology	5.51%	0.00%	5.51%
Foster Care Children	Home Health	5.51%	0.00%	5.51%
Foster Care Children	Emergency Transportation	2.51%	0.00%	2.51%
Foster Care Children	Non-Emergency Transportation	2.51%	0.00%	2.51%
Foster Care Children	Rehabilitation Services (OT, PT, ST)	5.51%	0.00%	5.51%
Foster Care Children	DME	5.51%	0.00%	5.51%
Foster Care Children	Clinic	3.77%	0.00%	3.77%
Foster Care Children	Family Planning	3.77%	0.00%	3.77%
Foster Care Children	Other	5.51%	0.00%	5.51%
Foster Care Children	Emergency Room	7.77%	2.54%	10.51%
Foster Care Children	Basic Behavioral Health	3.77%	0.00%	3.77%
Breast and Cervical Cancer	Inpatient Hospital	1.77%	0.00%	1.77%
Breast and Cervical Cancer	Outpatient Hospital	7.77%	2.55%	10.51%
Breast and Cervical Cancer	Primary Care Physician	3.77%	0.00%	3.77%
Breast and Cervical Cancer	Specialty Care Physician	3.77%	0.00%	3.77%
Breast and Cervical Cancer	FQHC/RHC	3.77%	0.00%	3.77%
Breast and Cervical Cancer	EPSDT	3.77%	0.00%	3.77%
Breast and Cervical Cancer	Certified Nurse Practitioners/Clinical Nurse	3.77%	0.00%	3.77%
Breast and Cervical Cancer	Lab/Radiology	5.51%	0.00%	5.51%
Breast and Cervical Cancer	Home Health	5.51%	0.00%	5.51%
Breast and Cervical Cancer	Emergency Transportation	2.51%	0.00%	2.51%
Breast and Cervical Cancer	Non-Emergency Transportation	2.51%	0.00%	2.51%
Breast and Cervical Cancer	Rehabilitation Services (OT, PT, ST)	5.51%	0.00%	5.51%
Breast and Cervical Cancer	DME	5.51%	0.00%	5.51%
Breast and Cervical Cancer	Clinic	3.77%	0.00%	3.77%

# MERCER

Page 10  
 April 8, 2011  
 Ms. Ruth Kennedy  
 Louisiana Department of Health and Hospitals

COA Description	COS Description	Utilization	Unit Cost	PMPM Trend
Breast and Cervical Cancer	Family Planning	3.77%	0.00%	3.77%
Breast and Cervical Cancer	Other	5.51%	0.00%	5.51%
Breast and Cervical Cancer	Emergency Room	7.77%	2.54%	10.51%
Breast and Cervical Cancer	Basic Behavioral Health	3.77%	0.00%	3.77%
Maternity Kickpayment	Maternity Kickpayment	0.00%	0.00%	0.00%

The overall annualized PMPM trend assumption for the CCN-P program is 3.67%.

## Programmatic Changes/Rate Issues

Programmatic change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base year. Mercer applied programmatic change adjustments to incorporate factors not fully reflected in the base data. These adjustments were mutually exclusive and made only once in the rate-setting process.

**Changes to Inpatient Hospital Reimbursement** – Various changes have been made to hospital per diem rates. Most recently, effective for dates of service on or after January 1, 2011, the inpatient per diem rates paid to non-State and non-Rural hospitals were reduced by 2 percent of the per diem rate on file as of December 31, 2010. The rural and state hospitals have been excluded from the rate reductions. The per diem rates for state hospitals have increased significantly since the base data period however this primarily affects the relative weights of the per diems versus cost settlements and has little impact on the total payment.

**Changes to the Laboratory/Radiology Fee Schedule** – There have been various changes to fee schedules. Most recently, effective for dates of service on or after January 1, 2011, the reimbursement rates for laboratory services was reduced by 2 percent of the fee amounts on file as of December 31, 2010.

## Outpatient Hospital Fee Schedule Changes

### Children's Specialty Hospital

Effective for dates of service on or after January 1, 2011, the reimbursement paid to Children's Specialty Hospitals for outpatient surgery is reduced by 2 percent of the fee schedule on file as of December 31, 2010.

From July 1, 2008 through February 19, 2009, Children's Specialty Hospitals were cost settled at 86.20% of cost. From February 20, 2009 through August 3, 2009, these hospitals were cost settled at 83.18% of cost. From August 4, 2009 through August 31, 2009, these hospitals were

# MERCER

Page 11

April 8, 2011

Ms. Ruth Kennedy

Louisiana Department of Health and Hospitals

cost settled at 78.48% of cost. From September 1, 2009 through February 2, 2010, these hospitals were cost settled at 97.00% of cost. From February 3, 2010 through July 31, 2010, these hospitals were cost settled at 92.15% of cost. Reimbursement going forward of 87.91% (August 1, 2010 – December 31, 2010) of allowable cost as calculated through the cost report settlement process will be reduced by 2%, making final reimbursement 86.15% (January 1, 2011 going forward).

### Non-State and Non-Rural Outpatient Hospitals

Again, there have been various changes to fee schedules. Most recently, effective for dates of service on or after January 1, 2011, the reimbursement paid to non-rural, non-state hospitals for outpatient surgery was reduced by 2 percent of the fee schedule on file as of December 31, 2010.

From July 1, 2008 through February 19, 2009, Non-Rural and Non-State outpatient hospitals (other than Children's) were cost settled at 86.20% of cost. From February 20, 2009 through August 3, 2009, these hospitals were cost settled at 83.18% of cost. From August 4, 2009 through February 2, 2010, these hospitals were cost settled at 78.48% of cost. From February 3, 2010 through July 31, 2010, these hospitals were cost settled at 74.56% of cost. Reimbursement going forward of 71.13% (August 1, 2010 – December 31, 2010) of allowable cost as calculated through the cost report settlement process will be reduced by 2%, making final reimbursement 69.71% (January 1, 2011 going forward).

### **Physician Fee Schedule Changes**

#### Members 16 years or older

Effective January 22, 2010, in general, the reimbursement for physician services rendered to recipients 16 years of age or older shall be reduced to 75% of the 2009 Louisiana Medicare Region 99 allowable or billed charges, whichever is lesser amount. Exceptions to the general rule are Prenatal E&M services (99201-99215 w/TH Modifier), Preventive E&M services (99381-99397), and Obstetrical Delivery Services (59400-59622). The Vaginal Delivery Services will be paid at 90% of the 2009 Louisiana Medicare Region 99 allowable or billed charges, whichever is lesser amount.

#### Members under 16 years

Effective January 22, 2010, the reimbursement for physician services rendered to recipients under 16 years of age shall be reduced to 90% of the 2009 Louisiana Medicare Region 99

# MERCER

Page 12  
April 8, 2011  
Ms. Ruth Kennedy  
Louisiana Department of Health and Hospitals

allowable or billed charges, whichever is lesser amount. In addition, effective August 1, 2010, DHH is no longer paying an enhanced fee for preventive services for members under 16 years.

## Physician Injectibles

Effective January 22, 2010, Physician injectibles are paid at 90% of the 2009 Medicare Average Sale Price (ASP).

## **Clinical Services-End Stage Renal Disease Facilities Non-Medicare Claims Reimbursement Rate Reduction**

Various changes, most recently, effective for dates of service on or after January 1, 2011, the reimbursement to ESRD facilities shall be reduced by 2 percent of the rates in effect on December 31, 2010.

**Non-Emergency Medical Transportation** – Most recently, effective for dates of service on or after January 1, 2011, the reimbursement rates for non-emergency, non-ambulance medical transportation services shall be reduced by 2 percent of the rates in effect on December 31, 2010.

**Emergency Medical Transportation** – Most recently, effective on or after January 1, 2011, the reimbursement rates for emergency ambulance transportation services shall be reduced by 2% of the rate on file as of December 31, 2010.

The compounded effect of all of the fee schedule changes by category of aid and category of service can be found in the table below. Overall, the fee schedule changes since the base data period reduced cost by approximately 7.87% for SFY09 and 5.39% for SFY10.

# MERCER

Page 13

April 8, 2011

Ms. Ruth Kennedy

Louisiana Department of Health and Hospitals

<b>Mercer COA Description</b>	<b>Final Mercer COS Description</b>	<b>Adjustment for Fee Schedule Changes (SFY09)</b>	<b>Adjustment for Fee Schedule Changes (SFY10)</b>
SSI	Inpatient Hospital	-6.01%	-4.57%
SSI	Outpatient Hospital	-10.88%	-4.18%
SSI	Primary Care Physician	-7.50%	-5.17%
SSI	Specialty Care Physician	-4.51%	-1.09%
SSI	FQHC/RHC	0.00%	0.00%
SSI	EPSDT	-0.25%	0.03%
SSI	Certified Nurse Practitioners/Clinical Nurse	-0.21%	-0.19%
SSI	Lab/Radiology	-15.92%	-8.72%
SSI	Home Health	0.00%	0.00%
SSI	Emergency Transportation	-4.90%	-2.76%
SSI	Non-Emergency Transportation	-9.09%	-7.04%
SSI	Rehabilitation Services (OT, PT, ST)	0.00%	0.00%
SSI	DME	0.00%	0.00%
SSI	Clinic	-10.35%	-8.25%
SSI	Family Planning	-7.68%	-5.50%
SSI	Other	-20.66%	-16.54%
SSI	Emergency Room	-12.24%	-7.60%
SSI	Basic Behavioral Health	-4.70%	-1.11%
Family and Children	Inpatient Hospital	-9.63%	-8.07%
Family and Children	Outpatient Hospital	-11.42%	-5.55%
Family and Children	Primary Care Physician	-6.80%	-6.32%
Family and Children	Specialty Care Physician	-6.00%	-6.04%
Family and Children	FQHC/RHC	0.00%	0.00%
Family and Children	EPSDT	2.00%	1.88%
Family and Children	Certified Nurse Practitioners/Clinical Nurse	-0.03%	-0.02%
Family and Children	Lab/Radiology	-14.40%	-7.94%
Family and Children	Home Health	0.00%	0.00%
Family and Children	Emergency Transportation	-4.90%	-2.76%
Family and Children	Non-Emergency Transportation	-9.09%	-7.04%

# MERCER

Page 14

April 8, 2011

Ms. Ruth Kennedy

Louisiana Department of Health and Hospitals

<b>Mercer COA Description</b>	<b>Final Mercer COS Description</b>	<b>Adjustment for Fee Schedule Changes (SFY09)</b>	<b>Adjustment for Fee Schedule Changes (SFY10)</b>
Family and Children	Rehabilitation Services (OT, PT, ST)	0.00%	0.00%
Family and Children	DME	0.00%	0.00%
Family and Children	Clinic	-1.43%	-1.09%
Family and Children	Family Planning	-6.13%	-4.81%
Family and Children	Other	-9.70%	-8.46%
Family and Children	Emergency Room	-11.46%	-7.58%
Family and Children	Basic Behavioral Health	-3.32%	0.99%
Foster Care Children	Inpatient Hospital	-9.62%	-5.56%
Foster Care Children	Outpatient Hospital	-10.22%	-5.79%
Foster Care Children	Primary Care Physician	-9.21%	-7.53%
Foster Care Children	Specialty Care Physician	-6.50%	-6.64%
Foster Care Children	FQHC/RHC	0.00%	0.00%
Foster Care Children	EPSDT	0.99%	0.93%
Foster Care Children	Certified Nurse Practitioners/Clinical Nurse	0.00%	0.00%
Foster Care Children	Lab/Radiology	-14.38%	-8.37%
Foster Care Children	Home Health	0.00%	0.00%
Foster Care Children	Emergency Transportation	-4.90%	-2.76%
Foster Care Children	Non-Emergency Transportation	-9.09%	-7.04%
Foster Care Children	Rehabilitation Services (OT, PT, ST)	0.00%	0.00%
Foster Care Children	DME	0.00%	0.00%
Foster Care Children	Clinic	-2.14%	-1.21%
Foster Care Children	Family Planning	-5.68%	-3.60%
Foster Care Children	Other	28.70%	-3.27%
Foster Care Children	Emergency Room	-10.89%	-7.19%
Foster Care Children	Basic Behavioral Health	-5.28%	0.34%
Breast and Cervical Cancer	Inpatient Hospital	-3.95%	-2.84%
Breast and Cervical Cancer	Outpatient Hospital	-10.16%	-2.31%
Breast and Cervical Cancer	Primary Care Physician	-12.29%	-2.82%

# MERCER

Page 15

April 8, 2011

Ms. Ruth Kennedy

Louisiana Department of Health and Hospitals

<b>Mercer COA Description</b>	<b>Final Mercer COS Description</b>	<b>Adjustment for Fee Schedule Changes (SFY09)</b>	<b>Adjustment for Fee Schedule Changes (SFY10)</b>
Breast and Cervical Cancer	Specialty Care Physician	-9.46%	-6.73%
Breast and Cervical Cancer	FQHC/RHC	0.00%	0.00%
Breast and Cervical Cancer	EPSDT	-19.73%	0.00%
Breast and Cervical Cancer	Certified Nurse Practitioners/Clinical Nurse	-0.02%	-0.03%
Breast and Cervical Cancer	Lab/Radiology	-16.39%	-9.57%
Breast and Cervical Cancer	Home Health	0.00%	0.00%
Breast and Cervical Cancer	Emergency Transportation	-4.90%	-2.76%
Breast and Cervical Cancer	Non-Emergency Transportation	-9.09%	-7.04%
Breast and Cervical Cancer	Rehabilitation Services (OT, PT, ST)	0.00%	0.00%
Breast and Cervical Cancer	DME	0.00%	0.00%
Breast and Cervical Cancer	Clinic	1.84%	-1.59%
Breast and Cervical Cancer	Family Planning	-10.80%	-4.51%
Breast and Cervical Cancer	Other	-39.33%	-7.55%
Breast and Cervical Cancer	Emergency Room	-11.32%	-6.30%
Breast and Cervical Cancer	Basic Behavioral Health	-4.76%	-2.27%
Maternity Kickpayment	Maternity Kickpayment	-8.43%	-6.24%

# MERCER

Page 16  
April 8, 2011  
Ms. Ruth Kennedy  
Louisiana Department of Health and Hospitals

## Data Smoothing

As part of the rate development process, Mercer blended data from SFY09 and SFY10 to arrive at the overall data source for rate setting. The goal of the blending process is to obtain a set of base data that has sufficient credibility and reasonableness to develop actuarially-sound capitation rates. Mercer applied weights of 60% and 40% to the SFY10 and SFY09 data respectively.

Beyond blending data from multiple years, Mercer also used Statewide figures where particular rate cells within a region had small enrollment. The cost per member per month for a small rate cell is subject to large fluctuations from one year to the next, thus rendering it less effective at predicting future cost. Using Statewide figures results in greater data credibility and reduces the impact of random fluctuations exhibited by the data.

Some categories of eligibility such as the Foster Children and Breast and Cervical Cancer population are too small to have separate rate cells due to data credibility concerns. Therefore, Statewide figures are used for these populations and the data has been combined across all age and sex cells in determining the capitation rate.

## Managed Care Assumptions

Mercer and DHH discussed areas for improvements in managed care efficiency. Prior studies of savings achieved in transitioning from fee-for-service to Managed Care showed savings of 2%-19%<sup>1</sup>.

Managed Care is able to generate savings by:

- Encouraging the use of preventive services so that acute conditions are not exacerbated to the point that requires a visit to the emergency room or hospitalization.
- Use of alternatives to the emergency room (ER) for conditions that are non-emergent in nature. Some Louisiana Medicaid recipients make very frequent use of the ER and ERs are much more expensive than other viable alternatives. Those alternatives, such as extended hours for doctor's offices, after-hours urgent care clinics, or even nurse advice lines, may result in significantly more pleasant experiences than the hospital ER as well.

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<sup>1</sup> The Lewin Group – Medicaid Capitation Expansion's Potential Cost Savings.

# MERCER

Page 17

April 8, 2011

Ms. Ruth Kennedy

Louisiana Department of Health and Hospitals

- By increasing access and providing member education, CCNs can steer some of the members away from the more costly emergency room setting when the condition is not emergent in nature.
- Minimizing duplication of services. When a recipient doesn't have a "medical home" or care coordinator, they often seek care from different providers, sometimes at different locations, each time they need care. The new provider must get to know them and their history over again and may order duplicative tests that have already been done by another provider. The provider that knows them may more easily focus in on their needs and provide more targeted care.
- Hospital discharge planning to ensure a smooth transition from facility-based care to community resources, and minimize readmissions.

Mercer has performed a study of the potentially preventable hospital admissions using the method prescribed by the Agency for Healthcare Research and Quality (AHRQ). The study confirmed that there were significant opportunities for savings due to hospital admissions associated with low birth weight babies, congestive heart failure, bacterial pneumonia, and other conditions which AHRQ has determined to be avoidable.

The table below illustrates the savings applied by category of aid and categories of service.

COA Description	COS Description	Utilization	Unit Cost	PMPM
SSI	Inpatient Hospital	-23.67%	2.12%	-22.05%
SSI	Outpatient Hospital	-18.67%	1.65%	-17.33%
SSI	Primary Care Physician	6.33%	5.55%	12.23%
SSI	Specialty Care Physician	-18.67%	0.56%	-18.22%
SSI	FQHC/RHC	1.33%	0.55%	1.89%
SSI	EPSDT	6.33%	5.55%	12.23%
SSI	Certified Nurse Practitioners/Clinical Nurse	6.33%	5.55%	12.23%
SSI	Lab/Radiology	-17.40%	0.57%	-16.93%
SSI	Home Health	1.30%	0.54%	1.85%
SSI	Emergency Transportation	-8.70%	0.54%	-8.20%
SSI	Non-Emergency Transportation	1.30%	0.54%	1.85%
SSI	Rehabilitation Services (OT, PT, ST)	-8.70%	0.54%	-8.20%
SSI	DME	-18.70%	0.54%	-18.26%

# MERCER

Page 18

April 8, 2011

Ms. Ruth Kennedy

Louisiana Department of Health and Hospitals

COA Description	COS Description	Utilization	Unit Cost	PMPM
SSI	Clinic	-18.67%	0.56%	-18.22%
SSI	Family Planning	1.33%	0.55%	1.89%
SSI	Other	1.30%	0.54%	1.85%
SSI	Emergency Room	-28.67%	5.66%	-24.63%
SSI	Basic Behavioral Health	1.33%	0.55%	1.89%
Family and Children	Inpatient Hospital	-33.70%	2.10%	-32.30%
Family and Children	Outpatient Hospital	-18.70%	1.64%	-17.37%
Family and Children	Primary Care Physician	6.30%	5.54%	12.19%
Family and Children	Specialty Care Physician	-18.70%	0.55%	-18.25%
Family and Children	FQHC/RHC	1.30%	0.54%	1.85%
Family and Children	EPSDT	6.30%	5.54%	12.19%
Family and Children	Certified Nurse Practitioners/Clinical Nurse	6.30%	5.54%	12.19%
Family and Children	Lab/Radiology	-17.40%	0.57%	-16.93%
Family and Children	Home Health	1.30%	0.54%	1.85%
Family and Children	Emergency Transportation	-8.70%	0.54%	-8.20%
Family and Children	Non-Emergency Transportation	1.30%	0.54%	1.85%
Family and Children	Rehabilitation Services (OT, PT, ST)	-8.70%	0.54%	-8.21%
Family and Children	DME	-18.70%	0.55%	-18.26%
Family and Children	Clinic	-18.70%	0.55%	-18.25%
Family and Children	Family Planning	1.30%	0.54%	1.85%
Family and Children	Other	1.30%	0.54%	1.85%
Family and Children	Emergency Room	-28.70%	5.65%	-24.67%
Family and Children	Basic Behavioral Health	1.30%	0.54%	1.85%
Foster Care Children	Inpatient Hospital	-23.67%	2.12%	-22.05%
Foster Care Children	Outpatient Hospital	-18.67%	1.65%	-17.33%
Foster Care Children	Primary Care Physician	6.33%	5.55%	12.23%
Foster Care Children	Specialty Care Physician	-18.67%	0.56%	-18.22%
Foster Care Children	FQHC/RHC	1.33%	0.55%	1.89%
Foster Care Children	EPSDT	6.33%	5.55%	12.23%
Foster Care Children	Certified Nurse Practitioners/Clinical Nurse	6.33%	5.55%	12.23%
Foster Care Children	Lab/Radiology	-17.40%	0.57%	-16.93%
Foster Care Children	Home Health	1.30%	0.54%	1.85%

# MERCER

Page 19

April 8, 2011

Ms. Ruth Kennedy

Louisiana Department of Health and Hospitals

COA Description	COS Description	Utilization	Unit Cost	PMPM
Foster Care Children	Emergency Transportation	-8.70%	0.54%	-8.20%
Foster Care Children	Non-Emergency Transportation	1.30%	0.54%	1.85%
Foster Care Children	Rehabilitation Services (OT, PT, ST)	-8.70%	0.54%	-8.20%
Foster Care Children	DME	-18.70%	0.55%	-18.26%
Foster Care Children	Clinic	-18.67%	0.56%	-18.22%
Foster Care Children	Family Planning	1.33%	0.55%	1.89%
Foster Care Children	Other	1.30%	0.54%	1.85%
Foster Care Children	Emergency Room	-28.67%	5.66%	-24.63%
Foster Care Children	Basic Behavioral Health	1.33%	0.55%	1.89%
Breast and Cervical Cancer	Inpatient Hospital	-23.67%	2.12%	-22.05%
Breast and Cervical Cancer	Outpatient Hospital	-18.67%	1.65%	-17.33%
Breast and Cervical Cancer	Primary Care Physician	6.33%	5.55%	12.23%
Breast and Cervical Cancer	Specialty Care Physician	-18.67%	0.56%	-18.22%
Breast and Cervical Cancer	FQHC/RHC	1.33%	0.55%	1.89%
Breast and Cervical Cancer	EPSDT	6.33%	5.56%	12.23%
Breast and Cervical Cancer	Certified Nurse Practitioners/Clinical Nurse	6.33%	5.55%	12.23%
Breast and Cervical Cancer	Lab/Radiology	-17.40%	0.57%	-16.93%
Breast and Cervical Cancer	Home Health	1.30%	0.54%	1.85%
Breast and Cervical Cancer	Emergency Transportation	-8.70%	0.54%	-8.20%
Breast and Cervical Cancer	Non-Emergency Transportation	1.30%	0.54%	1.85%
Breast and Cervical Cancer	Rehabilitation Services (OT, PT, ST)	-8.69%	0.54%	-8.19%
Breast and Cervical Cancer	DME	-18.70%	0.55%	-18.26%

# MERCER

Page 20  
 April 8, 2011  
 Ms. Ruth Kennedy  
 Louisiana Department of Health and Hospitals

COA Description	COS Description	Utilization	Unit Cost	PMPM
Breast and Cervical Cancer	Clinic	-18.67%	0.56%	-18.22%
Breast and Cervical Cancer	Family Planning	1.33%	0.55%	1.89%
Breast and Cervical Cancer	Other	1.31%	0.54%	1.85%
Breast and Cervical Cancer	Emergency Room	-28.67%	5.66%	-24.63%
Breast and Cervical Cancer	Basic Behavioral Health	1.33%	0.55%	1.88%
Maternity Kickpayment	Maternity Kickpayment	0.00%	0.50%	0.50%

The overall impact of managed care assumptions was a reduction of 14.69% to the rates.

## Commercial Reinsurance

To provide protection against the risk of catastrophic claims, the CCN-P plans are encouraged to purchase reinsurance to insure against large claims incurred by an individual member. Currently, under the FFS system, when the claims for members under 6 years exceed the expense threshold, an outlier payment is made outside of the MMIS system. To ensure sufficient consideration has been built into the rates so that plans can purchase reinsurance, outlier claims have been built into the capitation rates.

## Administration and Profit Load

Mercer and DHH reviewed the components of the administrative allowance to evaluate the administrative rates paid to the CCNs. The review focused on the reporting and organizational requirements detailed in the CCN provider agreement. Mercer modeled the cost structure for these requirements to determine the administrative load necessary for an average plan in this program. Based on the analysis and comparisons with other state Medicaid programs' administrative allowances, Mercer assumed an overall administration load of approximately 10.0% for the final premium rates.

In addition, Mercer included profit and margin considerations in the rate development explicitly through a load of 1.8% of premium. This is an acceptable rate consideration per AA.3.2 of the CMS Rate-Setting Checklist.

# MERCER

Page 21  
April 8, 2011  
Ms. Ruth Kennedy  
Louisiana Department of Health and Hospitals

In total, the overall load applied to the rates for administration and profit/contingencies was approximately 12%. We applied this as a load of 6.4% on the Maternity Kickpayment and a load of 12.7% on all other rate cells, which approximates the desired 12% aggregate loading.

## **Risk Adjustment**

Risk adjustment will be applied to the rates in exhibit A to reflect differences in health status of the members served in each plan using the ACG model. The risk adjustment process does not increase or decrease the overall cost of the program but can change the distribution across the various CCNs according to the relative risk of their enrolled members. Actuarially sound risk adjustment protocols have been developed so as to be appropriate to rates that have been developed by underlying age and gender cells.

## **Rate Ranges**

Mercer developed actuarially-sound rate ranges for DHH to use in determining the appropriate rates to pay the CCNs. Mercer specifically priced the upper and lower bound of the rate ranges by varying the assumptions outlined above. Mercer varied the trend assumptions and the financial data adjustments to account for different levels of managed care efficiency and potential risk selection. As a result, the lower bound of the rate range represents a rate for a very efficient CCN and the upper bound represents the least amount of efficiency DHH is willing to purchase. The final rates to be paid by DHH are within the ranges and are included as Attachment A to this letter.

## **Rate Development Overview**

To provide additional detail on the rate development, Mercer has also provided an overview of the adjustments applied to each rate cell in Attachment B. This exhibit presents the breakdown of the assumptions used to calculate the Target rate within the actuarially sound rate range.

## **Family Planning Portion of the Rates**

Mercer has analyzed the component of the rates associated with Family Planning services so that DHH may claim the enhanced federal match of 90% on these services. CMS issued a guide in June 2009 to assist States in determining which services are allowed to be claimed at the enhanced federal match rate. Specific details on codes used to identify family planning services can be found in the document accompanying this letter.

# MERCER

Page 22  
April 8, 2011  
Ms. Ruth Kennedy  
Louisiana Department of Health and Hospitals

Attachment C below contains the PMPMs associated with Family Planning that will be claimed at the enhanced match rate. Please note that these Family Planning PMPMs do not include load for administration and profit.

## **Certification of Final Rate Ranges**

In preparing the rate ranges underlying the rates shown in Attachment A, Mercer has used and relied upon enrollment, FFS claims, reimbursement level, benefit design, and information supplied by the Department of Health and Hospitals (DHH) and its fiscal agent. The DHH and its fiscal agent are responsible for the validity and completeness of this supplied data and information. We have reviewed the data and information for internal consistency and reasonableness but we did not audit it. In our opinion it is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

Mercer certifies that the rates in Attachment A were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid covered populations and services under the managed care contract. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rates and ranges developed by Mercer are actuarial projections of future contingent events. Actual CCN costs will differ from these projections. Mercer has developed these rates on behalf of DHH to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and in accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

CCNs are advised that the use of these rate ranges may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rate ranges by CCNs for any purpose. Mercer recommends that any CCN considering contracting with the DHH should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rate ranges before deciding whether to contract with the DHH.

This certification letter assumes the reader is familiar with the CCN program, Medicaid eligibility rules, and actuarial rating techniques. It is intended for DHH and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified

# MERCER

Page 23  
April 8, 2011  
Ms. Ruth Kennedy  
Louisiana Department of Health and Hospitals

professionals competent in the area of actuarial rate projections to understand the technical nature of these results.

If you have any questions on any of the information provided, please feel free to call Nick Simmons at 404 442 3196 and/or Sudha Shenoy at 404 442 3249.

Sincerely,



Nicholas J Simmons, FIA, FSA, MAAA  
Principal



Sudha Shenoy, FSA, MAAA, CERA  
Principal

Copy:  
Charles "Chip" Carbone - Mercer

# Attachment A CCN-P Rate Summary

		11/1/2012-12/31/2012					
DHH Administrative Region	Region Description	COA Description	RC Description	FY10 Member Months or Deliveries	CCN-P Final Rates (Gross of GME)	CCN-P Final Rates (Net of GME)	
					PMPM or Cost/Delivery	PMPM or Cost/Delivery	
					GME Adjustment		
01	New Orleans	SSI	0-2 Months, Male and Female	218	\$ 16,512.56	\$ 0.9572	\$ 15,806.47
01	New Orleans	SSI	3-11 Months, Male and Female	1,245	\$ 3,284.27	\$ 0.9523	\$ 3,127.74
01	New Orleans	SSI	1-5 Years, Male and Female	14,463	\$ 572.36	\$ 0.9680	\$ 554.04
01	New Orleans	SSI	6-13 Years, Male and Female	39,515	\$ 166.27	\$ 0.9770	\$ 162.45
01	New Orleans	SSI	14-18 Years, Male and Female	27,247	\$ 173.47	\$ 0.9663	\$ 167.63
01	New Orleans	SSI	19-44 Years, Male and Female	78,498	\$ 445.59	\$ 0.9158	\$ 408.08
01	New Orleans	SSI	45+ Years, Male and Female	102,751	\$ 700.67	\$ 0.9206	\$ 645.04
01	New Orleans	Family and Children	0-2 Months, Male and Female	33,497	\$ 1,136.52	\$ 0.8953	\$ 1,017.52
01	New Orleans	Family and Children	3-11 Months, Male and Female	77,569	\$ 168.65	\$ 0.9578	\$ 161.53
01	New Orleans	Family and Children	1-5 Years, Male and Female	445,431	\$ 71.99	\$ 0.9727	\$ 70.03
01	New Orleans	Family and Children	6-13 Years, Male and Female	513,322	\$ 45.20	\$ 0.9762	\$ 44.13
01	New Orleans	Family and Children	14-18 Years, Female	152,761	\$ 72.63	\$ 0.9721	\$ 70.61
01	New Orleans	Family and Children	14-18 Years, Male	137,012	\$ 53.70	\$ 0.9629	\$ 51.70
01	New Orleans	Family and Children	19-44 Years, Female	233,777	\$ 157.95	\$ 0.9540	\$ 150.68
01	New Orleans	Family and Children	19-44 Years, Male	9,515	\$ 174.84	\$ 0.9815	\$ 171.60
01	New Orleans	Family and Children	45+ Years, Female	12,329	\$ 270.13	\$ 0.9781	\$ 264.20
01	New Orleans	Family and Children	45+ Years, Male	3,010	\$ 304.71	\$ 0.9743	\$ 296.88
01	New Orleans	Foster Care Children	Foster Care, All Ages Male & Female	12,787	\$ 112.57	\$ 0.9816	\$ 110.50
01	New Orleans	Breast and Cervical Cancer	BCC, All Ages Female	2,121	\$ 1,725.82	\$ 0.9765	\$ 1,685.33
01	New Orleans	Maternity Kickpayment	Maternity Kickpayment, All Ages	7,448	\$ 6,886.49	\$ 0.9540	\$ 6,569.69
09	Mandeville	SSI	0-2 Months, Male and Female	109	\$ 16,512.56	\$ 0.9572	\$ 15,806.47
09	Mandeville	SSI	3-11 Months, Male and Female	455	\$ 3,284.27	\$ 0.9523	\$ 3,127.74
09	Mandeville	SSI	1-5 Years, Male and Female	6,506	\$ 572.36	\$ 0.9680	\$ 554.04
09	Mandeville	SSI	6-13 Years, Male and Female	16,269	\$ 166.27	\$ 0.9770	\$ 162.45
09	Mandeville	SSI	14-18 Years, Male and Female	10,589	\$ 173.47	\$ 0.9663	\$ 167.63
09	Mandeville	SSI	19-44 Years, Male and Female	37,522	\$ 394.83	\$ 0.9920	\$ 391.69
09	Mandeville	SSI	45+ Years, Male and Female	55,799	\$ 657.32	\$ 0.9955	\$ 654.36
09	Mandeville	Family and Children	0-2 Months, Male and Female	18,490	\$ 1,052.71	\$ 0.9960	\$ 1,048.53
09	Mandeville	Family and Children	3-11 Months, Male and Female	43,309	\$ 185.76	\$ 0.9957	\$ 184.96
09	Mandeville	Family and Children	1-5 Years, Male and Female	255,447	\$ 87.10	\$ 0.9975	\$ 86.89
09	Mandeville	Family and Children	6-13 Years, Male and Female	331,543	\$ 60.29	\$ 0.9973	\$ 60.12
09	Mandeville	Family and Children	14-18 Years, Female	91,154	\$ 94.34	\$ 0.9984	\$ 94.19
09	Mandeville	Family and Children	14-18 Years, Male	87,436	\$ 66.89	\$ 0.9984	\$ 66.79
09	Mandeville	Family and Children	19-44 Years, Female	103,701	\$ 193.12	\$ 0.9976	\$ 192.65
09	Mandeville	Family and Children	19-44 Years, Male	7,062	\$ 174.84	\$ 0.9815	\$ 171.60
09	Mandeville	Family and Children	45+ Years, Female	4,435	\$ 270.13	\$ 0.9781	\$ 264.20
09	Mandeville	Family and Children	45+ Years, Male	1,688	\$ 304.71	\$ 0.9743	\$ 296.88
09	Mandeville	Foster Care Children	Foster Care, All Ages Male & Female	19,963	\$ 112.57	\$ 0.9816	\$ 110.50
09	Mandeville	Breast and Cervical Cancer	BCC, All Ages Female	1,934	\$ 1,725.82	\$ 0.9765	\$ 1,685.33
09	Mandeville	Maternity Kickpayment	Maternity Kickpayment, All Ages	4,195	\$ 5,006.37	\$ 0.9969	\$ 4,991.02

# Attachment A CCN-P Rate Summary

3/1/2012-12/31/2012									
DHH Administrative Region	Region Description	COA Description	RC Description	FY10 Member Months or Deliveries	CCN-P Final Rates (Gross of GME)	GME Adjustment	CCN-P Final Rates (Net of GME)		
					PMPM or Cost/Delivery		PMPM or Cost/Delivery		
02	Baton Rouge	SSI	0-2 Months, Male and Female	256	\$ 16,543.54		\$ 15,836.37		
02	Baton Rouge	SSI	3-11 Months, Male and Female	1,073	\$ 3,292.01	0.9573	\$ 3,135.22		
02	Baton Rouge	SSI	1-5 Years, Male and Female	12,818	\$ 574.31	0.9680	\$ 555.96		
02	Baton Rouge	SSI	6-13 Years, Male and Female	27,870	\$ 166.90	0.9770	\$ 163.07		
02	Baton Rouge	SSI	14-18 Years, Male and Female	17,567	\$ 174.15	0.9664	\$ 168.29		
02	Baton Rouge	SSI	19-44 Years, Male and Female	47,779	\$ 451.13	0.9782	\$ 441.27		
02	Baton Rouge	SSI	45+ Years, Male and Female	63,731	\$ 634.63	0.9819	\$ 623.12		
02	Baton Rouge	Family and Children	0-2 Months, Male and Female	25,181	\$ 1,164.60	0.9815	\$ 1,143.09		
02	Baton Rouge	Family and Children	3-11 Months, Male and Female	56,838	\$ 179.67	0.9895	\$ 177.79		
02	Baton Rouge	Family and Children	1-5 Years, Male and Female	336,041	\$ 70.40	0.9930	\$ 69.91		
02	Baton Rouge	Family and Children	6-13 Years, Male and Female	424,802	\$ 44.53	0.9944	\$ 44.28		
02	Baton Rouge	Family and Children	14-18 Years, Female	119,392	\$ 75.28	0.9938	\$ 74.81		
02	Baton Rouge	Family and Children	14-18 Years, Male	110,422	\$ 52.85	0.9928	\$ 52.46		
02	Baton Rouge	Family and Children	19-44 Years, Female	149,867	\$ 158.79	0.9891	\$ 157.06		
02	Baton Rouge	Family and Children	19-44 Years, Male	5,812	\$ 175.53	0.9815	\$ 172.28		
02	Baton Rouge	Family and Children	45+ Years, Female	7,716	\$ 271.16	0.9781	\$ 265.22		
02	Baton Rouge	Family and Children	45+ Years, Male	1,340	\$ 305.80	0.9744	\$ 297.96		
02	Baton Rouge	Foster Care Children	Foster Care, All Ages Male & Female	10,904	\$ 113.02	0.9817	\$ 110.95		
02	Baton Rouge	Breast and Cervical Cancer	BCC, All Ages Female	1,531	\$ 1,737.49	0.9765	\$ 1,696.74		
02	Baton Rouge	Maternity Kickpayment	Maternity Kickpayment, All Ages	5,633	\$ 5,235.76	0.9964	\$ 5,217.03		
03	Thibodaux	SSI	0-2 Months, Male and Female	190	\$ 16,543.54	0.9573	\$ 15,836.37		
03	Thibodaux	SSI	3-11 Months, Male and Female	577	\$ 3,292.01	0.9524	\$ 3,135.22		
03	Thibodaux	SSI	1-5 Years, Male and Female	7,824	\$ 574.31	0.9680	\$ 555.96		
03	Thibodaux	SSI	6-13 Years, Male and Female	20,987	\$ 166.90	0.9770	\$ 163.07		
03	Thibodaux	SSI	14-18 Years, Male and Female	12,940	\$ 174.15	0.9664	\$ 168.29		
03	Thibodaux	SSI	19-44 Years, Male and Female	37,213	\$ 347.23	0.9766	\$ 339.11		
03	Thibodaux	SSI	45+ Years, Male and Female	46,801	\$ 627.61	0.9782	\$ 613.90		
03	Thibodaux	Family and Children	0-2 Months, Male and Female	16,509	\$ 1,006.89	0.9704	\$ 977.10		
03	Thibodaux	Family and Children	3-11 Months, Male and Female	37,403	\$ 183.49	0.9881	\$ 181.31		
03	Thibodaux	Family and Children	1-5 Years, Male and Female	213,492	\$ 85.36	0.9918	\$ 84.66		
03	Thibodaux	Family and Children	6-13 Years, Male and Female	267,180	\$ 57.27	0.9933	\$ 56.89		
03	Thibodaux	Family and Children	14-18 Years, Female	79,499	\$ 103.78	0.9929	\$ 103.04		
03	Thibodaux	Family and Children	14-18 Years, Male	73,746	\$ 69.01	0.9913	\$ 68.41		
03	Thibodaux	Family and Children	19-44 Years, Female	100,355	\$ 200.36	0.9868	\$ 197.73		
03	Thibodaux	Family and Children	19-44 Years, Male	5,123	\$ 175.53	0.9815	\$ 172.28		
03	Thibodaux	Family and Children	45+ Years, Female	3,680	\$ 271.16	0.9781	\$ 265.22		
03	Thibodaux	Family and Children	45+ Years, Male	1,015	\$ 305.80	0.9744	\$ 297.96		
03	Thibodaux	Foster Care Children	Foster Care, All Ages Male & Female	6,367	\$ 113.02	0.9817	\$ 110.95		
03	Thibodaux	Breast and Cervical Cancer	BCC, All Ages Female	1,073	\$ 1,737.49	0.9765	\$ 1,696.74		
03	Thibodaux	Maternity Kickpayment	Maternity Kickpayment, All Ages	3,633	\$ 5,186.08	0.9853	\$ 5,109.85		

# Attachment A CCN-P Rate Summary

## CCN-P REQUEST FOR PROPOSALS

3/1/2012-12/31/2012									
DHH Administrative Region	Region Description	COA Description	RC Description	FY10 Member Months or Deliveries	CCN-P Final Rates (Gross of GME)	GME Adjustment	CCN-P Final Rates (Net of GME)	PMPM or Cost/Delivery	PMPM or Cost/Delivery
04	LaFayette	SSI	0-2 Months, Male and Female	241	\$ 16,543.54	0.9573	\$ 15,836.37		
04	LaFayette	SSI	3-11 Months, Male and Female	1,009	\$ 3,292.01	0.9524	\$ 3,135.22		
04	LaFayette	SSI	1-5 Years, Male and Female	10,033	\$ 574.31	0.9680	\$ 555.96		
04	LaFayette	SSI	6-13 Years, Male and Female	20,942	\$ 166.90	0.9770	\$ 163.07		
04	LaFayette	SSI	14-18 Years, Male and Female	13,191	\$ 174.15	0.9664	\$ 168.29		
04	LaFayette	SSI	19-44 Years, Male and Female	50,949	\$ 378.50	0.9822	\$ 371.77		
04	LaFayette	SSI	45+ Years, Male and Female	75,776	\$ 567.85	0.9826	\$ 557.95		
04	LaFayette	Family and Children	0-2 Months, Male and Female	25,893	\$ 1,161.88	0.9760	\$ 1,134.05		
04	LaFayette	Family and Children	3-11 Months, Male and Female	58,513	\$ 194.08	0.9868	\$ 191.52		
04	LaFayette	Family and Children	1-5 Years, Male and Female	326,436	\$ 79.44	0.9912	\$ 78.74		
04	LaFayette	Family and Children	6-13 Years, Male and Female	420,910	\$ 52.12	0.9931	\$ 51.76		
04	LaFayette	Family and Children	14-18 Years, Female	118,613	\$ 84.36	0.9920	\$ 83.68		
04	LaFayette	Family and Children	14-18 Years, Male	110,594	\$ 58.24	0.9898	\$ 57.65		
04	LaFayette	Family and Children	19-44 Years, Female	137,629	\$ 170.07	0.9896	\$ 168.30		
04	LaFayette	Family and Children	19-44 Years, Male	7,959	\$ 175.53	0.9815	\$ 172.28		
04	LaFayette	Family and Children	45+ Years, Female	5,373	\$ 271.16	0.9781	\$ 265.22		
04	LaFayette	Family and Children	45+ Years, Male	1,712	\$ 305.80	0.9744	\$ 297.96		
04	LaFayette	Foster Care Children	Foster Care, All Ages Male & Female	17,383	\$ 113.02	0.9817	\$ 110.95		
04	LaFayette	Breast and Cervical Cancer	BCC, All Ages Female	1,428	\$ 1,737.49	0.9765	\$ 1,696.74		
04	LaFayette	Maternity Kickpayment	Maternity Kickpayment, All Ages	5,865	\$ 4,555.74	0.9991	\$ 4,551.69		

# Attachment A CCN-P Rate Summary

5/1/2012-12/31/2012									
DHH Administrative Region	Region Description	COA Description	RC Description	FY10 Member Months or Deliveries	CCN-P Final Rates (Gross of GME)	GME Adjustment	CCN-P Final Rates (Net of GME)		
					PMPM or Cost/Delivery		PMPM or Cost/Delivery		
05	Lake Charles	SSI	0-2 Months, Male and Female	103	\$ 16,574.62		\$ 15,866.36		
05	Lake Charles	SSI	3-11 Months, Male and Female	498	\$ 3,299.78		\$ 3,142.72		
05	Lake Charles	SSI	1-5 Years, Male and Female	4,324	\$ 576.28		\$ 557.89		
05	Lake Charles	SSI	6-13 Years, Male and Female	10,075	\$ 167.54		\$ 163.70		
05	Lake Charles	SSI	14-18 Years, Male and Female	5,898	\$ 174.83		\$ 168.96		
05	Lake Charles	SSI	19-44 Years, Male and Female	20,136	\$ 359.08		\$ 358.49		
05	Lake Charles	SSI	45+ Years, Male and Female	28,765	\$ 609.68		\$ 608.48		
05	Lake Charles	Family and Children	0-2 Months, Male and Female	12,072	\$ 1,146.43		\$ 1,141.75		
05	Lake Charles	Family and Children	3-11 Months, Male and Female	27,288	\$ 194.35		\$ 193.82		
05	Lake Charles	Family and Children	1-5 Years, Male and Female	154,451	\$ 85.12		\$ 85.07		
05	Lake Charles	Family and Children	6-13 Years, Male and Female	197,659	\$ 58.90		\$ 58.86		
05	Lake Charles	Family and Children	14-18 Years, Female	53,654	\$ 94.98		\$ 94.94		
05	Lake Charles	Family and Children	14-18 Years, Male	51,009	\$ 64.09		\$ 64.06		
05	Lake Charles	Family and Children	19-44 Years, Female	52,599	\$ 198.62		\$ 198.52		
05	Lake Charles	Family and Children	19-44 Years, Male	2,684	\$ 176.21		\$ 172.96		
05	Lake Charles	Family and Children	45+ Years, Female	1,715	\$ 272.20		\$ 266.24		
05	Lake Charles	Family and Children	45+ Years, Male	473	\$ 306.91		\$ 299.05		
05	Lake Charles	Foster Care Children	Foster Care, All Ages Male & Female	10,081	\$ 113.47		\$ 111.39		
05	Lake Charles	Breast and Cervical Cancer	BCC, All Ages Female	780	\$ 1,749.26		\$ 1,708.25		
05	Lake Charles	Maternity Kickpayment	Maternity Kickpayment, All Ages	2,699	\$ 4,716.66		\$ 4,708.91		
06	Alexandria	SSI	0-2 Months, Male and Female	151	\$ 16,574.62		\$ 15,866.36		
06	Alexandria	SSI	3-11 Months, Male and Female	535	\$ 3,299.78		\$ 3,142.72		
06	Alexandria	SSI	1-5 Years, Male and Female	6,265	\$ 576.28		\$ 557.89		
06	Alexandria	SSI	6-13 Years, Male and Female	15,447	\$ 167.54		\$ 163.70		
06	Alexandria	SSI	14-18 Years, Male and Female	9,554	\$ 174.83		\$ 168.96		
06	Alexandria	SSI	19-44 Years, Male and Female	33,689	\$ 321.02		\$ 319.06		
06	Alexandria	SSI	45+ Years, Male and Female	41,654	\$ 581.30		\$ 579.07		
06	Alexandria	Family and Children	0-2 Months, Male and Female	12,559	\$ 1,296.27		\$ 1,291.22		
06	Alexandria	Family and Children	3-11 Months, Male and Female	29,209	\$ 201.15		\$ 200.55		
06	Alexandria	Family and Children	1-5 Years, Male and Female	168,417	\$ 94.88		\$ 94.68		
06	Alexandria	Family and Children	6-13 Years, Male and Female	223,939	\$ 60.14		\$ 60.05		
06	Alexandria	Family and Children	14-18 Years, Female	63,993	\$ 99.04		\$ 98.83		
06	Alexandria	Family and Children	14-18 Years, Male	59,733	\$ 67.34		\$ 67.18		
06	Alexandria	Family and Children	19-44 Years, Female	62,895	\$ 187.57		\$ 187.02		
06	Alexandria	Family and Children	19-44 Years, Male	3,791	\$ 176.21		\$ 172.96		
06	Alexandria	Family and Children	45+ Years, Female	2,107	\$ 272.20		\$ 266.24		
06	Alexandria	Family and Children	45+ Years, Male	651	\$ 306.91		\$ 299.05		
06	Alexandria	Foster Care Children	Foster Care, All Ages Male & Female	10,979	\$ 113.47		\$ 111.39		
06	Alexandria	Breast and Cervical Cancer	BCC, All Ages Female	686	\$ 1,749.26		\$ 1,708.25		
06	Alexandria	Maternity Kickpayment	Maternity Kickpayment, All Ages	2,817	\$ 4,831.36		\$ 4,817.69		

# Attachment A CCN-P Rate Summary

5/1/2012-12/31/2012									
DHH Administrative Region	Region Description	COA Description	RC Description	FY10 Member Months or Deliveries	CCN-P Final Rates (Gross of GME)	GME Adjustment	CCN-P Final Rates (Net of GME)		
					PMPM or Cost/Delivery		PMPM or Cost/Delivery		
07	Shreveport	SSI	0-2 Months, Male and Female	273	\$ 16,574.62		\$ 15,866.36		
07	Shreveport	SSI	3-11 Months, Male and Female	1,167	\$ 3,299.78		\$ 3,142.72		
07	Shreveport	SSI	1-5 Years, Male and Female	13,246	\$ 576.28		\$ 557.89		
07	Shreveport	SSI	6-13 Years, Male and Female	30,446	\$ 167.54		\$ 163.70		
07	Shreveport	SSI	14-18 Years, Male and Female	20,251	\$ 174.83		\$ 168.96		
07	Shreveport	SSI	19-44 Years, Male and Female	55,236	\$ 417.26		\$ 392.78		
07	Shreveport	SSI	45+ Years, Male and Female	64,022	\$ 627.87		\$ 593.98		
07	Shreveport	Family and Children	0-2 Months, Male and Female	21,441	\$ 1,274.07		\$ 1,177.96		
07	Shreveport	Family and Children	3-11 Months, Male and Female	48,977	\$ 200.33		\$ 192.86		
07	Shreveport	Family and Children	1-5 Years, Male and Female	287,394	\$ 83.97		\$ 81.74		
07	Shreveport	Family and Children	6-13 Years, Male and Female	364,405	\$ 49.02		\$ 48.06		
07	Shreveport	Family and Children	14-18 Years, Female	102,998	\$ 92.45		\$ 90.30		
07	Shreveport	Family and Children	14-18 Years, Male	92,118	\$ 55.51		\$ 54.24		
07	Shreveport	Family and Children	19-44 Years, Female	113,294	\$ 190.38		\$ 183.40		
07	Shreveport	Family and Children	19-44 Years, Male	3,647	\$ 176.21		\$ 172.96		
07	Shreveport	Family and Children	45+ Years, Female	4,287	\$ 272.20		\$ 266.24		
07	Shreveport	Family and Children	45+ Years, Male	803	\$ 306.91		\$ 299.05		
07	Shreveport	Foster Care Children	Foster Care, All Ages Male & Female	12,260	\$ 113.47		\$ 111.39		
07	Shreveport	Breast and Cervical Cancer	BCC, All Ages Female	1,161	\$ 1,749.26		\$ 1,708.25		
07	Shreveport	Maternity Kickpayment	Maternity Kickpayment, All Ages	4,743	\$ 5,188.16		\$ 5,187.21		
08	Monroe	SSI	0-2 Months, Male and Female	123	\$ 16,574.62		\$ 15,866.36		
08	Monroe	SSI	3-11 Months, Male and Female	621	\$ 3,299.78		\$ 3,142.72		
08	Monroe	SSI	1-5 Years, Male and Female	7,356	\$ 576.28		\$ 557.89		
08	Monroe	SSI	6-13 Years, Male and Female	18,521	\$ 167.54		\$ 163.70		
08	Monroe	SSI	14-18 Years, Male and Female	12,113	\$ 174.83		\$ 168.96		
08	Monroe	SSI	19-44 Years, Male and Female	35,899	\$ 338.09		\$ 334.96		
08	Monroe	SSI	45+ Years, Male and Female	43,661	\$ 609.51		\$ 603.78		
08	Monroe	Family and Children	0-2 Months, Male and Female	16,160	\$ 1,364.21		\$ 1,347.66		
08	Monroe	Family and Children	3-11 Months, Male and Female	37,261	\$ 216.21		\$ 214.86		
08	Monroe	Family and Children	1-5 Years, Male and Female	215,906	\$ 92.62		\$ 92.22		
08	Monroe	Family and Children	6-13 Years, Male and Female	284,305	\$ 57.04		\$ 56.83		
08	Monroe	Family and Children	14-18 Years, Female	81,887	\$ 97.61		\$ 97.20		
08	Monroe	Family and Children	14-18 Years, Male	77,549	\$ 66.73		\$ 66.40		
08	Monroe	Family and Children	19-44 Years, Female	97,644	\$ 170.41		\$ 169.34		
08	Monroe	Family and Children	19-44 Years, Male	4,323	\$ 176.21		\$ 172.96		
08	Monroe	Family and Children	45+ Years, Female	3,589	\$ 272.20		\$ 266.24		
08	Monroe	Family and Children	45+ Years, Male	784	\$ 306.91		\$ 299.05		
08	Monroe	Foster Care Children	Foster Care, All Ages Male & Female	9,459	\$ 113.47		\$ 111.39		
08	Monroe	Breast and Cervical Cancer	BCC, All Ages Female	1,197	\$ 1,749.26		\$ 1,708.25		
08	Monroe	Maternity Kickpayment	Maternity Kickpayment, All Ages	3,756	\$ 5,355.44		\$ 5,354.54		



# Attachment B Rate Development Overview

11/1/2012-12/31/2012												
DHH Administrative Region	Region Description	COA Description	RC Description	Weighted FY09 and FY10 PMPM at FY10	Trend	Projected FFS PMPM	MC Savings	PMPM Post-IC Savings	PMPM Post Smoothing w/Statewide	Premium Load	Proposed CCN-P Premium (Gross of GME)	Proposed CCN-P Premium (Net of GME)
				PMPM or Cost/Delivery		PMPM or Cost/Delivery		PMPM or Cost/Delivery	PMPM or Cost/Delivery		PMPM or Cost/Delivery	PMPM or Cost/Delivery
01	New Orleans	SSI	0-2 Months, Male and Female	\$ 18,006.49	-2.10%	\$ 18,967.82	-20.56%	\$ 15,065.07	\$ 14,412.67	12.7%	\$ 16,512.56	\$ 15,806.47
01	New Orleans	SSI	3-11 Months, Male and Female	\$ 3,425.43	2.48%	\$ 3,642.14	-19.20%	\$ 2,942.98	\$ 2,866.60	12.7%	\$ 3,284.27	\$ 3,121.74
01	New Orleans	SSI	1-5 Years, Male and Female	\$ 613.22	3.32%	\$ 665.47	-15.97%	\$ 559.23	\$ 499.56	12.7%	\$ 572.36	\$ 554.04
01	New Orleans	SSI	6-13 Years, Male and Female	\$ 129.12	4.41%	\$ 144.19	-13.19%	\$ 124.85	\$ 145.12	12.7%	\$ 166.27	\$ 162.45
01	New Orleans	SSI	14-18 Years, Male and Female	\$ 148.02	4.30%	\$ 164.45	-16.02%	\$ 138.11	\$ 151.41	12.7%	\$ 173.47	\$ 167.63
01	New Orleans	SSI	19-44 Years, Male and Female	\$ 429.97	3.93%	\$ 473.43	-17.85%	\$ 388.93	\$ 388.93	12.7%	\$ 445.59	\$ 408.08
01	New Orleans	SSI	45+ Years, Male and Female	\$ 1,272.88	4.06%	\$ 1,340.40	-17.73%	\$ 1,115.77	\$ 1,115.77	12.7%	\$ 1,266.60	\$ 1,217.52
01	New Orleans	Family and Children	0-2 Months, Male and Female	\$ 67.30	2.09%	\$ 71.34	-26.00%	\$ 53.40	\$ 53.40	12.7%	\$ 61.53	\$ 59.53
01	New Orleans	Family and Children	3-11 Months, Male and Female	\$ 164.29	3.64%	\$ 178.88	-12.75%	\$ 147.19	\$ 147.19	12.7%	\$ 168.65	\$ 161.53
01	New Orleans	Family and Children	1-5 Years, Male and Female	\$ 63.71	4.36%	\$ 70.88	-11.36%	\$ 62.83	\$ 62.83	12.7%	\$ 71.99	\$ 70.03
01	New Orleans	Family and Children	6-13 Years, Male and Female	\$ 39.97	4.43%	\$ 44.55	-11.45%	\$ 39.45	\$ 39.45	12.7%	\$ 45.20	\$ 44.13
01	New Orleans	Family and Children	14-18 Years, Female	\$ 66.49	4.67%	\$ 74.53	-14.94%	\$ 63.39	\$ 63.39	12.7%	\$ 72.63	\$ 70.61
01	New Orleans	Family and Children	19-44 Years, Male	\$ 50.60	4.30%	\$ 56.22	-16.64%	\$ 46.87	\$ 46.87	12.7%	\$ 53.70	\$ 51.70
01	New Orleans	Family and Children	19-44 Years, Female	\$ 151.91	4.46%	\$ 169.42	-18.63%	\$ 137.86	\$ 137.86	12.7%	\$ 157.95	\$ 150.68
01	New Orleans	Family and Children	19-44 Years, Male and Female	\$ 153.73	4.04%	\$ 169.72	-20.42%	\$ 135.06	\$ 135.06	12.7%	\$ 157.95	\$ 150.68
01	New Orleans	Family and Children	45+ Years, Female	\$ 216.22	4.25%	\$ 239.95	-18.87%	\$ 194.63	\$ 194.63	12.7%	\$ 220.13	\$ 214.60
01	New Orleans	Family and Children	48+ Years, Male	\$ 285.79	4.00%	\$ 314.14	-20.36%	\$ 224.63	\$ 224.63	12.7%	\$ 260.71	\$ 256.88
01	New Orleans	Foster Care Children	Foster Care, All Ages, Male & Female	\$ 126.78	4.04%	\$ 139.99	-13.51%	\$ 121.07	\$ 121.07	12.7%	\$ 140.71	\$ 136.88
01	New Orleans	Breast and Cervical Cancer	Breast and Cervical Cancer	\$ 1,499.97	8.37%	\$ 1,633.61	-17.52%	\$ 1,512.37	\$ 1,512.37	12.7%	\$ 1,725.82	\$ 1,685.33
01	New Orleans	Maternity Kickpayment	Maternity Kickpayment, All Ages	\$ 6,415.49	0.00%	\$ 6,415.49	0.50%	\$ 6,447.57	\$ 6,447.57	6.4%	\$ 6,886.49	\$ 6,569.69
09	Mandeville	SSI	0-2 Months, Male and Female	\$ 17,813.84	2.06%	\$ 18,746.79	-21.04%	\$ 14,802.37	\$ 14,412.67	12.7%	\$ 16,512.56	\$ 15,806.47
09	Mandeville	SSI	3-11 Months, Male and Female	\$ 3,684.24	2.76%	\$ 3,943.62	-17.98%	\$ 3,233.61	\$ 3,233.61	12.7%	\$ 3,284.27	\$ 3,121.74
09	Mandeville	SSI	1-5 Years, Male and Female	\$ 623.55	3.96%	\$ 687.19	-12.15%	\$ 603.72	\$ 499.56	12.7%	\$ 572.36	\$ 554.04
09	Mandeville	SSI	6-13 Years, Male and Female	\$ 162.23	4.92%	\$ 182.91	-8.50%	\$ 167.36	\$ 145.12	12.7%	\$ 166.27	\$ 162.45
09	Mandeville	SSI	14-18 Years, Male and Female	\$ 152.83	5.13%	\$ 173.18	-11.67%	\$ 152.97	\$ 151.41	12.7%	\$ 173.47	\$ 167.63
09	Mandeville	SSI	19-44 Years, Male and Female	\$ 369.22	4.82%	\$ 415.37	-17.03%	\$ 344.62	\$ 344.62	12.7%	\$ 394.83	\$ 391.69
09	Mandeville	SSI	45+ Years, Male and Female	\$ 618.37	4.58%	\$ 691.65	-17.05%	\$ 573.74	\$ 573.74	12.7%	\$ 657.32	\$ 654.36
09	Mandeville	Family and Children	0-2 Months, Male and Female	\$ 1,161.82	2.21%	\$ 1,227.05	-25.12%	\$ 918.79	\$ 918.79	12.7%	\$ 1,052.71	\$ 1,048.53
09	Mandeville	Family and Children	3-11 Months, Male and Female	\$ 164.61	3.80%	\$ 180.72	-10.29%	\$ 162.13	\$ 162.13	12.7%	\$ 185.76	\$ 184.96
09	Mandeville	Family and Children	1-5 Years, Male and Female	\$ 75.80	4.46%	\$ 84.53	-10.07%	\$ 76.02	\$ 76.02	12.7%	\$ 87.10	\$ 86.89
09	Mandeville	Family and Children	6-13 Years, Male and Female	\$ 52.37	4.53%	\$ 58.50	-10.06%	\$ 52.62	\$ 52.62	12.7%	\$ 60.29	\$ 60.12
09	Mandeville	Family and Children	14-18 Years, Female	\$ 83.06	5.04%	\$ 93.92	-12.34%	\$ 82.34	\$ 82.34	12.7%	\$ 94.19	\$ 94.19
09	Mandeville	Family and Children	19-44 Years, Male	\$ 59.72	4.88%	\$ 67.27	-13.21%	\$ 58.38	\$ 58.38	12.7%	\$ 66.89	\$ 66.79
09	Mandeville	Family and Children	19-44 Years, Female	\$ 180.79	4.91%	\$ 203.80	-17.30%	\$ 168.55	\$ 168.55	12.7%	\$ 193.12	\$ 192.65
09	Mandeville	Family and Children	45+ Years, Male	\$ 185.41	4.59%	\$ 207.39	-19.38%	\$ 167.21	\$ 167.21	12.7%	\$ 174.84	\$ 171.60
09	Mandeville	Family and Children	45+ Years, Female	\$ 291.82	4.45%	\$ 325.38	-17.34%	\$ 288.98	\$ 288.98	12.7%	\$ 270.13	\$ 264.20
09	Mandeville	Family and Children	45+ Years, Male and Female	\$ 397.93	3.83%	\$ 437.12	-20.64%	\$ 346.91	\$ 346.91	12.7%	\$ 304.71	\$ 296.88
09	Mandeville	Foster Care Children	Foster Care, All Ages, Male & Female	\$ 93.01	4.91%	\$ 104.84	-8.84%	\$ 95.57	\$ 95.57	12.7%	\$ 112.57	\$ 110.50
09	Mandeville	Breast and Cervical Cancer	Breast and Cervical Cancer	\$ 860.22	7.52%	\$ 1,031.10	-16.80%	\$ 857.86	\$ 1,506.44	12.7%	\$ 1,725.82	\$ 1,685.33
09	Mandeville	Maternity Kickpayment	Maternity Kickpayment, All Ages	\$ 4,663.96	0.00%	\$ 4,663.96	0.50%	\$ 4,687.28	\$ 4,687.28	6.4%	\$ 5,006.37	\$ 4,991.02



# Attachment B Rate Development Overview

3/1/2012-12/31/2012

DHH Administrative Region	Region Description	COA Description	RC Description	Weighted FY09 and FY10 PMPM at FY10	Trend	Projected FFS PMPM	MC Savings	PMPM Post MC Savings	PMPM Post Smoothing w/Statewide	Premium Load	Proposed CCN-P Premium (Gross of GME)	GME Adjustment	Proposed CCN-P Premium (Net of GME)
02	Baton Rouge	SSI	0-2 Months, Male and Female	\$ 19,115.24	-2.12%	\$ 20,180.87	-20.26%	\$ 16,091.43	\$ 14,439.80	12.7%	\$ 16,543.54	0.9573	\$ 15,836.37
02	Baton Rouge	SSI	3-11 Months, Male and Female	\$ 3,584.84	2.60%	\$ 3,630.49	-17.94%	\$ 3,143.19	\$ 2,873.37	12.7%	\$ 3,292.01	0.9524	\$ 3,132.22
02	Baton Rouge	SSI	1-5 Years, Male and Female	\$ 479.22	3.94%	\$ 523.48	-12.23%	\$ 464.71	\$ 501.27	12.7%	\$ 574.31	0.9680	\$ 555.96
02	Baton Rouge	SSI	6-13 Years, Male and Female	\$ 147.43	4.01%	\$ 163.17	-12.36%	\$ 142.98	\$ 145.67	12.7%	\$ 166.90	0.9770	\$ 163.07
02	Baton Rouge	SSI	14-18 Years, Male and Female	\$ 142.66	4.49%	\$ 159.81	-13.23%	\$ 138.67	\$ 152.00	12.7%	\$ 174.15	0.9664	\$ 168.29
02	Baton Rouge	SSI	19-44 Years, Male and Female	\$ 431.25	4.07%	\$ 478.12	-17.64%	\$ 393.76	\$ 393.76	12.7%	\$ 441.27	0.9782	\$ 411.27
02	Baton Rouge	SSI	46+ Years, Male and Female	\$ 591.66	4.74%	\$ 666.92	-16.94%	\$ 553.93	\$ 553.93	12.7%	\$ 634.63	0.9819	\$ 623.12
02	Baton Rouge	Family and Children	0-2 Months, Male and Female	\$ 1,314.14	2.03%	\$ 1,384.28	-26.57%	\$ 1,016.45	\$ 1,016.45	12.7%	\$ 1,164.60	0.9815	\$ 1,143.09
02	Baton Rouge	Family and Children	3-11 Months, Male and Female	\$ 165.27	3.50%	\$ 180.61	-13.18%	\$ 166.81	\$ 156.81	12.7%	\$ 179.67	0.9886	\$ 177.79
02	Baton Rouge	Family and Children	1-5 Years, Male and Female	\$ 61.09	4.33%	\$ 68.16	-9.85%	\$ 61.44	\$ 61.44	12.7%	\$ 70.40	0.9930	\$ 69.91
02	Baton Rouge	Family and Children	6-13 Years, Male and Female	\$ 38.30	4.39%	\$ 42.80	-9.20%	\$ 38.86	\$ 38.86	12.7%	\$ 44.53	0.9944	\$ 44.28
02	Baton Rouge	Family and Children	14-18 Years, Female	\$ 66.56	4.77%	\$ 75.07	-12.47%	\$ 65.70	\$ 65.70	12.7%	\$ 75.28	0.9938	\$ 74.81
02	Baton Rouge	Family and Children	19-44 Years, Male	\$ 47.24	4.63%	\$ 53.10	-13.14%	\$ 46.12	\$ 46.12	12.7%	\$ 52.85	0.9928	\$ 52.46
02	Baton Rouge	Family and Children	46+ Years, Male	\$ 149.92	4.85%	\$ 169.42	-18.19%	\$ 138.60	\$ 138.60	12.7%	\$ 158.79	0.9891	\$ 157.06
02	Baton Rouge	Family and Children	19-44 Years, Female	\$ 179.06	4.44%	\$ 200.33	-19.94%	\$ 160.39	\$ 160.39	12.7%	\$ 175.63	0.9815	\$ 172.28
02	Baton Rouge	Family and Children	45+ Years, Female	\$ 240.29	4.66%	\$ 270.32	-17.85%	\$ 222.03	\$ 236.67	12.7%	\$ 271.16	0.9781	\$ 265.22
02	Baton Rouge	Family and Children	46+ Years, Male	\$ 238.63	4.36%	\$ 266.41	-19.09%	\$ 215.54	\$ 266.91	12.7%	\$ 305.80	0.9744	\$ 297.96
02	Baton Rouge	Foster Care Children	Foster Care, All Ages, Male & Female	\$ 88.05	8.81%	\$ 99.40	-8.23%	\$ 91.22	\$ 98.64	12.7%	\$ 113.02	0.9817	\$ 110.95
02	Baton Rouge	Breast and Cervical Cancer	BCC, All Ages, Female	\$ 1,576.27	4.1%	\$ 1,937.28	-17.10%	\$ 1,605.96	\$ 1,516.64	12.7%	\$ 1,737.49	0.9765	\$ 1,696.74
02	Baton Rouge	Maternity Kickpayment	Maternity Kickpayment, All Ages	\$ 4,877.66	0.00%	\$ 4,877.66	0.50%	\$ 4,902.05	\$ 4,902.05	6.4%	\$ 5,235.76	0.9964	\$ 5,217.03
03	Thibodaux	SSI	0-2 Months, Male and Female	\$ 17,265.71	2.03%	\$ 18,183.65	-20.71%	\$ 14,418.37	\$ 14,439.80	12.7%	\$ 16,543.54	0.9573	\$ 15,836.37
03	Thibodaux	SSI	3-11 Months, Male and Female	\$ 2,966.26	2.60%	\$ 3,169.51	-17.90%	\$ 2,602.32	\$ 2,873.37	12.7%	\$ 3,292.01	0.9524	\$ 3,132.22
03	Thibodaux	SSI	1-5 Years, Male and Female	\$ 344.36	4.37%	\$ 384.63	-11.43%	\$ 340.67	\$ 501.27	12.7%	\$ 574.31	0.9680	\$ 555.96
03	Thibodaux	SSI	6-13 Years, Male and Female	\$ 119.61	4.94%	\$ 135.47	-10.36%	\$ 121.43	\$ 145.67	12.7%	\$ 166.90	0.9770	\$ 163.07
03	Thibodaux	SSI	14-18 Years, Male and Female	\$ 132.88	5.32%	\$ 151.91	-12.79%	\$ 132.49	\$ 152.00	12.7%	\$ 174.15	0.9664	\$ 168.29
03	Thibodaux	SSI	19-44 Years, Male and Female	\$ 320.37	5.30%	\$ 366.14	-17.22%	\$ 303.08	\$ 303.08	12.7%	\$ 347.23	0.9762	\$ 339.11
03	Thibodaux	Family and Children	0-2 Months, Male and Female	\$ 580.71	5.32%	\$ 663.91	-17.49%	\$ 547.81	\$ 547.81	12.7%	\$ 627.61	0.9782	\$ 613.90
03	Thibodaux	Family and Children	3-11 Months, Male and Female	\$ 161.33	3.84%	\$ 177.83	-9.94%	\$ 160.15	\$ 160.15	12.7%	\$ 183.49	0.9881	\$ 181.31
03	Thibodaux	Family and Children	1-5 Years, Male and Female	\$ 73.58	4.51%	\$ 82.46	-9.66%	\$ 74.50	\$ 74.50	12.7%	\$ 84.86	0.9913	\$ 84.86
03	Thibodaux	Family and Children	6-13 Years, Male and Female	\$ 48.86	4.68%	\$ 54.98	-9.09%	\$ 49.99	\$ 49.99	12.7%	\$ 57.27	0.9933	\$ 56.89
03	Thibodaux	Family and Children	14-18 Years, Female	\$ 90.57	5.00%	\$ 102.73	-11.83%	\$ 90.58	\$ 90.58	12.7%	\$ 103.78	0.9929	\$ 103.04
03	Thibodaux	Family and Children	19-44 Years, Male	\$ 61.36	4.92%	\$ 69.46	-13.28%	\$ 60.23	\$ 69.46	12.7%	\$ 81.00	0.9913	\$ 79.84
03	Thibodaux	Family and Children	46+ Years, Male	\$ 185.30	4.97%	\$ 210.06	-16.75%	\$ 174.88	\$ 174.88	12.7%	\$ 200.36	0.9868	\$ 197.73
03	Thibodaux	Family and Children	19-44 Years, Male	\$ 186.72	4.78%	\$ 221.91	-20.35%	\$ 176.73	\$ 153.20	12.7%	\$ 175.53	0.9815	\$ 172.28
03	Thibodaux	Family and Children	46+ Years, Female	\$ 327.25	4.36%	\$ 365.39	-20.16%	\$ 291.66	\$ 236.67	12.7%	\$ 271.16	0.9781	\$ 265.22
03	Thibodaux	Family and Children	45+ Years, Male	\$ 286.01	4.76%	\$ 322.52	-20.34%	\$ 256.91	\$ 266.91	12.7%	\$ 305.80	0.9744	\$ 297.96
03	Thibodaux	Foster Care Children	Foster Care, All Ages, Male & Female	\$ 110.65	4.47%	\$ 123.87	-9.87%	\$ 111.65	\$ 98.64	12.7%	\$ 113.02	0.9817	\$ 110.95
03	Thibodaux	Breast and Cervical Cancer	BCC, All Ages, Female	\$ 2,155.88	8.99%	\$ 2,692.77	-17.39%	\$ 2,224.37	\$ 1,516.64	12.7%	\$ 1,737.49	0.9765	\$ 1,696.74
03	Thibodaux	Maternity Kickpayment	Maternity Kickpayment, All Ages	\$ 4,831.38	0.00%	\$ 4,831.38	0.50%	\$ 4,855.54	\$ 4,855.54	6.4%	\$ 5,186.08	0.9853	\$ 5,109.85
04	LaFayette	SSI	0-2 Months, Male and Female	\$ 18,157.98	2.11%	\$ 19,166.35	-19.40%	\$ 15,447.71	\$ 14,439.80	12.7%	\$ 16,543.54	0.9573	\$ 15,836.37
04	LaFayette	SSI	3-11 Months, Male and Female	\$ 3,132.27	2.78%	\$ 3,381.97	-17.19%	\$ 2,784.01	\$ 2,873.37	12.7%	\$ 3,292.01	0.9524	\$ 3,132.22
04	LaFayette	SSI	1-5 Years, Male and Female	\$ 642.80	4.15%	\$ 714.00	-9.40%	\$ 646.92	\$ 501.27	12.7%	\$ 574.31	0.9680	\$ 555.96
04	LaFayette	SSI	6-13 Years, Male and Female	\$ 161.66	4.74%	\$ 182.19	-8.73%	\$ 166.28	\$ 145.67	12.7%	\$ 166.90	0.9770	\$ 163.07
04	LaFayette	SSI	14-18 Years, Male and Female	\$ 202.60	4.14%	\$ 225.00	-14.15%	\$ 193.17	\$ 152.00	12.7%	\$ 174.15	0.9664	\$ 168.29
04	LaFayette	SSI	19-44 Years, Male and Female	\$ 351.78	4.69%	\$ 396.01	-16.56%	\$ 330.37	\$ 330.37	12.7%	\$ 378.50	0.9822	\$ 371.77
04	LaFayette	SSI	46+ Years, Male and Female	\$ 527.16	4.75%	\$ 594.25	-16.59%	\$ 495.64	\$ 495.64	12.7%	\$ 567.85	0.9826	\$ 557.95
04	LaFayette	Family and Children	0-2 Months, Male and Female	\$ 1,275.24	2.16%	\$ 1,347.67	-24.75%	\$ 1,014.03	\$ 1,014.03	12.7%	\$ 1,161.88	0.9760	\$ 1,134.05
04	LaFayette	Family and Children	3-11 Months, Male and Female	\$ 175.74	3.69%	\$ 193.00	-12.23%	\$ 169.39	\$ 169.39	12.7%	\$ 194.08	0.9868	\$ 191.52
04	LaFayette	Family and Children	1-5 Years, Male and Female	\$ 69.75	4.31%	\$ 77.79	-10.87%	\$ 69.33	\$ 69.33	12.7%	\$ 79.44	0.9912	\$ 78.74
04	LaFayette	Family and Children	6-13 Years, Male and Female	\$ 44.47	4.45%	\$ 50.18	-9.34%	\$ 45.49	\$ 45.49	12.7%	\$ 52.12	0.9931	\$ 51.76
04	LaFayette	Family and Children	14-18 Years, Female	\$ 74.47	4.90%	\$ 84.27	-12.63%	\$ 73.63	\$ 73.63	12.7%	\$ 83.68	0.9920	\$ 83.68
04	LaFayette	Family and Children	19-44 Years, Male	\$ 52.13	4.72%	\$ 58.72	-13.44%	\$ 50.83	\$ 50.83	12.7%	\$ 58.24	0.9898	\$ 57.65
04	LaFayette	Family and Children	46+ Years, Female	\$ 188.03	4.83%	\$ 218.55	-16.86%	\$ 184.44	\$ 148.44	12.7%	\$ 170.07	0.9896	\$ 168.30
04	LaFayette	Family and Children	19-44 Years, Male	\$ 145.13	4.85%	\$ 164.00	-18.41%	\$ 133.81	\$ 133.81	12.7%	\$ 153.20	0.9815	\$ 152.28
04	LaFayette	Family and Children	45+ Years, Female	\$ 246.72	4.59%	\$ 277.02	-17.21%	\$ 229.35	\$ 236.67	12.7%	\$ 271.16	0.9781	\$ 265.22
04	LaFayette	Family and Children	46+ Years, Male	\$ 248.87	4.36%	\$ 277.89	-19.29%	\$ 224.28	\$ 224.28	12.7%	\$ 266.91	0.9864	\$ 267.96
04	LaFayette	Foster Care Children	Foster Care, All Ages, Male & Female	\$ 92.32	5.00%	\$ 104.72	-9.87%	\$ 96.16	\$ 98.64	12.7%	\$ 113.02	0.9817	\$ 110.95
04	LaFayette	Breast and Cervical Cancer	BCC, All Ages, Female	\$ 1,919.10	7.56%	\$ 2,316.70	-17.41%	\$ 1,913.33	\$ 1,516.64	12.7%	\$ 1,737.49	0.9765	\$ 1,696.74
04	LaFayette	Maternity Kickpayment	Maternity Kickpayment, All Ages	\$ 4,244.15	0.00%	\$ 4,244.15	0.50%	\$ 4,265.38	\$ 4,265.38	6.4%	\$ 4,555.74	0.9991	\$ 4,551.69

# Attachment B Rate Development Overview

		5/1/2012-12/31/2012										5/1/2012-12/31/2012									
		State Fiscal Year 2009 Rate Development					State Fiscal Year 2010 Rate Development					State Fiscal Year 2009 Rate Development					State Fiscal Year 2010 Rate Development				
DHH Administrative Region	Region Description	COA Description	RC Description	FY09 CCN-P Base PMPM	Completion Factor	Program Integrity Recoupments (Fraud & Abuse)	IP and OP Hospital Settlements	Fee Schedule Changes	PMPM or Cost/Delivery	FY09 CCN-P Post Adjustments	Trend to FY10	Projected FY10 CCN-P PMPM	PMPM or Cost/Delivery	FY10 CCN-P Base PMPM	Completion Factor	Program Integrity Recoupments (Fraud & Abuse)	IP and OP Hospital Settlements	Fee Schedule Changes	PMPM or Cost/Delivery	FY10 CCN-P Post Adjustments	
05	Lake Charles	SSI	0-2 Months, Male and Female	\$ 20,048.80	1.0019	0.9969	1.0111	0.9412	\$ 19,056.59	2.1%	\$ 19,448.86	\$ 10,551.61	1.0610	0.9985	1.0092	0.9610	1.0092	0.9610	\$ 10,841.85		
05	Lake Charles	SSI	3-11 Months, Male and Female	\$ 2,970.97	1.0012	0.9976	1.0103	0.9485	\$ 2,843.42	3.0%	\$ 2,928.07	\$ 1,774.40	1.0583	0.9989	1.0082	0.9637	1.0082	0.9637	\$ 1,822.36		
05	Lake Charles	SSI	1-5 Years, Male and Female	\$ 493.92	0.9999	0.9986	1.0106	0.9601	\$ 478.54	4.8%	\$ 501.54	\$ 551.46	1.0467	0.9992	1.0053	0.9738	1.0053	0.9738	\$ 564.55		
05	Lake Charles	SSI	6-13 Years, Male and Female	\$ 125.22	0.9999	0.9983	1.0165	0.9362	\$ 118.94	5.1%	\$ 124.96	\$ 211.74	1.0506	0.9991	1.0074	0.9634	1.0074	0.9634	\$ 115.70		
05	Lake Charles	SSI	14-18 Years, Male and Female	\$ 128.85	0.9999	0.9982	1.0173	0.9275	\$ 121.35	5.2%	\$ 127.63	\$ 135.32	1.0435	0.9990	1.0052	0.9618	1.0052	0.9618	\$ 136.38		
05	Lake Charles	SSI	19-44 Years, Male and Female	\$ 292.39	1.0000	0.9982	1.0170	0.9239	\$ 274.22	5.1%	\$ 288.17	\$ 355.39	1.0457	0.9992	1.0075	0.9584	1.0075	0.9584	\$ 357.83		
05	Lake Charles	SSI	45+ Years, Male and Female	\$ 540.64	1.0002	0.9977	1.0217	0.9256	\$ 511.38	4.8%	\$ 536.01	\$ 579.95	1.0471	0.9991	1.0085	0.9577	1.0085	0.9577	\$ 595.72		
05	Lake Charles	Family and Children	0-2 Months, Male and Female	\$ 1,301.64	1.0017	0.9972	1.0097	0.9137	\$ 1,198.58	2.2%	\$ 1,225.36	\$ 1,297.97	1.0501	0.9989	1.0091	0.9277	1.0091	0.9277	\$ 1,274.56		
05	Lake Charles	Family and Children	3-11 Months, Male and Female	\$ 173.75	0.9979	0.9981	1.0079	0.9346	\$ 163.01	3.7%	\$ 169.10	\$ 180.36	1.0323	0.9985	1.0051	0.9473	1.0051	0.9473	\$ 175.09		
05	Lake Charles	Family and Children	1-5 Years, Male and Female	\$ 72.90	0.9966	0.9983	1.0112	0.9285	\$ 68.09	4.6%	\$ 71.19	\$ 77.19	1.0237	0.9981	1.0039	0.9484	1.0039	0.9484	\$ 77.09		
05	Lake Charles	Family and Children	6-13 Years, Male and Female	\$ 50.78	0.9963	0.9984	1.0112	0.9278	\$ 47.39	4.6%	\$ 49.59	\$ 52.98	1.0219	0.9981	1.0034	0.9518	1.0034	0.9518	\$ 54.61		
05	Lake Charles	Family and Children	14-18 Years, Male and Female	\$ 83.08	0.9962	0.9986	1.0141	0.9192	\$ 77.04	5.0%	\$ 80.90	\$ 87.59	1.0216	0.9987	1.0041	0.9474	1.0041	0.9474	\$ 89.02		
05	Lake Charles	Family and Children	19-44 Years, Male	\$ 58.33	0.9963	0.9983	1.0137	0.9175	\$ 53.96	5.0%	\$ 56.67	\$ 59.19	1.0228	0.9985	1.0043	0.9486	1.0043	0.9486	\$ 60.41		
05	Lake Charles	Family and Children	45+ Years, Male	\$ 185.98	0.9972	0.9983	1.0205	0.9076	\$ 171.47	4.9%	\$ 179.93	\$ 193.30	1.0273	0.9982	1.0066	0.9384	1.0066	0.9384	\$ 207.43		
05	Lake Charles	Family and Children	19-44 Years, Female	\$ 211.17	0.9964	0.9979	1.0189	0.9056	\$ 194.00	4.5%	\$ 202.65	\$ 219.49	1.0232	0.9988	1.0051	0.9416	1.0051	0.9416	\$ 231.58		
05	Lake Charles	Family and Children	45+ Years, Female	\$ 248.51	0.9973	0.9980	1.0236	0.9074	\$ 229.73	5.0%	\$ 241.26	\$ 261.59	1.0348	0.9986	1.0077	0.9341	1.0077	0.9341	\$ 292.00		
05	Lake Charles	Family and Children	45+ Years, Male	\$ 426.52	0.9992	0.9977	1.0178	0.9071	\$ 392.59	3.9%	\$ 407.78	\$ 398.07	1.0286	0.9986	1.0082	0.9349	1.0082	0.9349	\$ 465.40		
05	Lake Charles	Foster Care Children	Foster Care, All Ages Male & Female	\$ 104.84	0.9998	0.9980	1.0199	0.9212	\$ 98.29	5.3%	\$ 103.49	\$ 98.30	1.0406	0.9985	1.0059	0.9557	1.0059	0.9557	\$ 101.68		
05	Lake Charles	Breast and Cervical Cancer	BCC, All Ages Female	\$ 1,443.40	0.9985	0.9973	1.0178	0.9091	\$ 1,385.02	9.2%	\$ 1,512.65	\$ 1,529.29	1.0281	0.9995	1.0157	0.9700	1.0157	0.9700	\$ 1,570.12		
05	Lake Charles	Maternity Kickpayment	Maternity Kickpayment, All Ages	\$ 4,801.23	1.0000	1.0000	1.0000	0.9157	\$ 4,396.41	0.0%	\$ 4,396.41	\$ 4,685.03	1.0000	1.0000	1.0000	0.9376	1.0000	0.9376	\$ 4,392.51		
06	Alexandria	SSI	0-2 Months, Male and Female	\$ 22,589.70	1.0019	0.9989	1.0117	0.9406	\$ 21,469.85	2.0%	\$ 21,909.74	\$ 13,348.51	1.0602	0.9980	1.0132	0.9602	1.0132	0.9602	\$ 13,720.85		
06	Alexandria	SSI	3-11 Months, Male and Female	\$ 2,859.99	1.0017	0.9999	1.0092	0.9413	\$ 2,713.36	2.4%	\$ 2,777.16	\$ 4,118.79	1.0631	0.9994	1.0177	0.9593	1.0177	0.9593	\$ 4,258.83		
06	Alexandria	SSI	1-5 Years, Male and Female	\$ 538.32	1.0007	0.9978	1.0093	0.9469	\$ 506.87	3.7%	\$ 525.71	\$ 324.18	1.0455	0.9990	1.0035	0.9677	1.0035	0.9677	\$ 379.79		
06	Alexandria	SSI	6-13 Years, Male and Female	\$ 170.35	1.0004	0.9980	1.0098	0.9398	\$ 158.82	4.0%	\$ 165.14	\$ 164.57	1.0459	0.9990	1.0042	0.9648	1.0042	0.9648	\$ 169.69		
06	Alexandria	SSI	14-18 Years, Male and Female	\$ 141.82	1.0000	0.9984	1.0091	0.9320	\$ 130.79	4.8%	\$ 137.07	\$ 134.22	1.0387	0.9991	1.0013	0.9589	1.0013	0.9589	\$ 133.87		
06	Alexandria	SSI	19-44 Years, Male and Female	\$ 311.66	1.0002	0.9981	1.0092	0.9266	\$ 285.45	4.7%	\$ 298.74	\$ 293.57	1.0441	0.9991	1.0042	0.9546	1.0042	0.9546	\$ 293.60		
06	Alexandria	Family and Children	45+ Years, Male and Female	\$ 573.48	1.0003	0.9987	1.0089	0.9328	\$ 546.63	4.4%	\$ 546.63	\$ 534.29	1.0474	0.9991	1.0049	0.9568	1.0049	0.9568	\$ 571.54		
06	Alexandria	Family and Children	0-2 Months, Male and Female	\$ 1,367.32	1.0020	0.9971	1.0089	0.9141	\$ 1,259.92	2.1%	\$ 1,286.82	\$ 1,546.94	1.0514	0.9990	1.0128	0.9272	1.0128	0.9272	\$ 1,525.71		
06	Alexandria	Family and Children	3-11 Months, Male and Female	\$ 188.93	0.9963	0.9981	1.0098	0.9328	\$ 175.97	3.6%	\$ 186.64	\$ 186.64	1.0302	0.9986	1.0047	0.9482	1.0047	0.9482	\$ 182.92		
06	Alexandria	Family and Children	1-5 Years, Male and Female	\$ 84.65	0.9971	0.9983	1.0091	0.9317	\$ 77.80	4.2%	\$ 81.08	\$ 87.80	1.0235	0.9984	1.0015	0.9506	1.0015	0.9506	\$ 85.23		
06	Alexandria	Family and Children	6-13 Years, Male and Female	\$ 51.82	0.9963	0.9985	1.0090	0.9333	\$ 47.58	4.5%	\$ 49.72	\$ 54.91	1.0197	0.9983	0.9989	0.9584	0.9989	0.9584	\$ 63.40		
06	Alexandria	Family and Children	14-18 Years, Female	\$ 91.65	0.9964	0.9986	1.0093	0.9201	\$ 86.54	4.9%	\$ 86.54	\$ 91.81	1.0213	0.9983	1.0000	0.9464	1.0000	0.9464	\$ 93.65		
06	Alexandria	Family and Children	19-44 Years, Male	\$ 62.02	0.9967	0.9985	1.0096	0.9221	\$ 56.15	4.8%	\$ 58.83	\$ 63.11	1.0223	0.9988	1.0005	0.9486	1.0005	0.9486	\$ 71.16		
06	Alexandria	Family and Children	45+ Years, Female	\$ 185.98	0.9973	0.9983	1.0092	0.9090	\$ 165.36	4.8%	\$ 173.22	\$ 184.41	1.0267	0.9992	1.0015	0.9371	1.0015	0.9371	\$ 217.54		
06	Alexandria	Family and Children	19-44 Years, Female	\$ 197.31	0.9977	0.9982	1.0093	0.9123	\$ 176.92	4.6%	\$ 185.04	\$ 176.30	1.0258	0.9988	1.0009	0.9371	1.0009	0.9371	\$ 219.44		
06	Alexandria	Family and Children	45+ Years, Male	\$ 456.81	0.9984	0.9975	1.0091	0.9091	\$ 410.36	3.6%	\$ 425.18	\$ 311.88	1.0237	0.9988	1.0024	0.9372	1.0024	0.9372	\$ 367.34		
06	Alexandria	Family and Children	45+ Years, Male	\$ 508.69	0.9984	0.9975	1.0095	0.9076	\$ 453.66	3.7%	\$ 470.43	\$ 413.38	1.0362	0.9990	1.0051	0.9325	1.0051	0.9325	\$ 401.07		
06	Alexandria	Foster Care Children	Foster Care, All Ages Male & Female	\$ 103.55	1.0002	0.9981	1.0093	0.9245	\$ 94.91	4.4%	\$ 99.10	\$ 83.75	1.0386	0.9985	1.0011	0.9558	1.0011	0.9558	\$ 83.11		
06	Alexandria	Breast and Cervical Cancer	BCC, All Ages Female	\$ 2,139.67	0.9989	0.9972	1.0129	0.9060	\$ 1,762.76	8.0%	\$ 1,904.07	\$ 1,434.37	1.0362	0.9993	0.9956	0.9621	0.9956	0.9621	\$ 1,422.72		
06	Alexandria	Maternity Kickpayment	Maternity Kickpayment, All Ages	\$ 4,935.96	1.0000	1.0000	1.0000	0.9157	\$ 4,519.77	0.0%	\$ 4,519.77	\$ 4,787.26	1.0000	1.0000	1.0000	0.9376	1.0000	0.9376	\$ 4,488.35		
07	Shreveport	SSI	0-2 Months, Male and Female	\$ 7,838.59	1.0014	0.9969	1.0214	0.9405	\$ 7,136.02	2.3%	\$ 7,347.80	\$ 15,519.26	1.0635	0.9987	0.9984	0.9564	0.9984	0.9564	\$ 15,772.94		
07	Shreveport	SSI	3-11 Months, Male and Female	\$ 2,902.93	1.0016	0.9971	1.0273	0.9407	\$ 3,485.12	2.3%	\$ 3,565.19	\$ 3,697.43	1.0601	0.9989	1.0166	0.9609	1.0166	0.9609	\$ 3,824.70		
07	Shreveport	SSI	1-5 Years, Male and Female	\$ 300.31	1.0004	0.9979	1.0273	0.9416	\$ 322.21	3.9%	\$ 334.76	\$ 360.05	1.0520	0.9992	1.0424	0.9637	1.0424	0.9637	\$ 380.17		
07	Shreveport	SSI	6-13 Years, Male and Female	\$ 116.19	1.0001	0.9980	1.0269	0.9362	\$ 120.05	4.5%	\$ 125.40	\$ 121.42	1.0453	0.9990	1.0668	0.9629	1.0668	0.9629	\$ 130.25		
07	Shreveport	SSI	14-18 Years, Male and Female	\$ 154.99	1.0004	0.9979	1.0269	0.9304	\$ 164.58	4.1%	\$ 171.29	\$ 177.09	1.0499	0.9993	1.0562	0.9569	1.0562	0.9569	\$ 198.39		
07	Shreveport	SSI	19-44 Years, Male and Female	\$ 356.35	1.0005	0.9978	1.0269	0.9276	\$ 363.93	3.9%	\$ 398.90	\$ 372.50	1.0514	0.9995	1.0609	0.9539	1.0609	0.9539	\$ 396.25		
07	Shreveport	Family and Children	45+ Years, Male and Female	\$ 549.37	1.0004	0.9970	1.0269	0.9274	\$ 580.28	4.1%	\$ 604.18	\$ 529.95	1.0493	0.9990	1.0742	0.9449	1.0742	0.9449	\$ 584.42		
07	Shreveport	Family and Children	0-2 Months, Male and Female	\$ 1,389.33	1.0022	0.9970	1.0272	0.9096	\$ 1,607.07	2.0%	\$ 1,638.90	\$ 1,306.21	1.0515	0.9990	1.0036	0.9257	1.				

# Attachment B Rate Development Overview

		5/1/2012-12/31/2012														
		State Fiscal Year 2009 Rate Development					State Fiscal Year 2010 Rate Development									
DHH Administrative Region	Region Description	COA Description	RC Description	Adjustments			Trend to FY10	FY09 CCN-P		Projected FY10 CCN-P PMPM	Adjustments		FY10 CCN-P Base PMPM	FY10 CCN-P PMPM Post Adjustments		
				Completion Factor	Program Integrity Recoupments (Fraud & Abuse)	IP and OP Hospital Cost Settlements		Fee Schedule Changes	PMPM or Cost/Delivery		PMPM or Cost/Delivery	Program Integrity Recoupments (Fraud & Abuse)		IP and OP Hospital Cost Settlements	Fee Schedule Changes	Completion Factor
08	Monroe	SSI	0-2 Months, Male and Female	1.0018	0.9969	1.0431	0.9387	\$ 12,554.38	2.2%	\$ 12,824.30	1.0624	0.9985	1.0200	0.9564	\$ 18,863.07	\$ 18,863.07
08	Monroe	SSI	3-11 Months, Male and Female	1.0007	0.9977	1.0121	0.9484	\$ 1,675.27	3.8%	\$ 1,738.64	1.0576	0.9989	1.0164	0.9623	\$ 2,291.57	\$ 2,291.57
08	Monroe	SSI	1-5 Years, Male and Female	1.0009	0.9979	1.0080	0.9504	\$ 845.73	3.5%	\$ 875.68	1.0498	0.9992	1.0105	0.9709	\$ 509.60	\$ 509.60
08	Monroe	SSI	6-13 Years, Male and Female	1.0008	0.9978	1.0168	0.9407	\$ 201.77	3.8%	\$ 209.47	1.0461	0.9991	1.0092	0.9668	\$ 167.08	\$ 167.08
08	Monroe	SSI	14-18 Years, Male and Female	0.9989	0.9982	1.0382	0.9306	\$ 141.02	5.3%	\$ 148.49	1.0466	0.9992	1.0100	0.9618	\$ 170.68	\$ 170.68
08	Monroe	SSI	19-44 Years, Male and Female	1.0004	0.9979	1.0280	0.9247	\$ 296.78	4.6%	\$ 310.29	1.0475	0.9994	1.0117	0.9535	\$ 318.85	\$ 318.85
08	Monroe	SSI	45+ Years, Male and Female	1.0004	0.9977	1.0431	0.9251	\$ 570.37	4.7%	\$ 597.25	1.0479	0.9992	1.0115	0.9557	\$ 505.56	\$ 505.56
08	Monroe	Family and Children	0-2 Months, Male and Female	1.0019	0.9971	0.9942	0.9120	\$ 1,411.32	2.2%	\$ 1,442.01	1.0502	0.9988	1.0194	0.9262	\$ 1,475.19	\$ 1,475.19
08	Monroe	Family and Children	3-11 Months, Male and Female	0.9955	0.9979	1.0073	0.9277	\$ 220.80	3.3%	\$ 228.04	1.0296	0.9987	1.0081	0.9509	\$ 173.00	\$ 173.00
08	Monroe	Family and Children	1-5 Years, Male and Female	0.9972	0.9984	1.0288	0.9311	\$ 77.96	4.4%	\$ 81.40	1.0244	0.9986	1.0054	0.9522	\$ 40.84	\$ 40.84
08	Monroe	Family and Children	6-13 Years, Male and Female	0.9966	0.9985	1.0292	0.9327	\$ 47.16	4.5%	\$ 49.29	1.0215	0.9985	1.0037	0.9566	\$ 49.06	\$ 49.06
08	Monroe	Family and Children	14-18 Years, Female	0.9966	0.9986	1.0346	0.9228	\$ 82.79	4.8%	\$ 86.74	1.0230	0.9980	1.0045	0.9489	\$ 89.44	\$ 89.44
08	Monroe	Family and Children	14-18 Years, Male	0.9970	0.9984	1.0333	0.9234	\$ 57.77	4.7%	\$ 60.52	1.0241	0.9989	1.0053	0.9482	\$ 59.47	\$ 59.47
08	Monroe	Family and Children	19-44 Years, Female	0.9978	0.9982	1.0409	0.9069	\$ 160.16	4.7%	\$ 167.72	1.0284	0.9992	1.0076	0.9377	\$ 161.65	\$ 161.65
08	Monroe	Family and Children	19-44 Years, Male	0.9979	0.9980	1.0444	0.9146	\$ 183.44	4.6%	\$ 191.93	1.0279	0.9991	1.0073	0.9405	\$ 185.50	\$ 185.50
08	Monroe	Family and Children	45+ Years, Female	0.9960	0.9978	1.0601	0.9079	\$ 289.21	4.7%	\$ 302.73	1.0326	0.9989	1.0101	0.9364	\$ 260.34	\$ 260.34
08	Monroe	Family and Children	45+ Years, Male	1.0001	0.9974	1.0263	0.9078	\$ 400.67	3.5%	\$ 414.80	1.0364	0.9989	1.0122	0.9317	\$ 409.13	\$ 409.13
08	Monroe	Foster Care Children	Foster Care, All Ages Male & Female	0.9966	0.9986	1.0289	0.9278	\$ 75.59	5.4%	\$ 79.70	1.0380	0.9985	1.0037	0.9562	\$ 81.64	\$ 81.64
08	Monroe	Breast and Cervical Cancer	BCC, All Ages Female	0.9980	0.9974	1.1706	0.9013	\$ 1,188.10	8.1%	\$ 1,284.77	1.0316	0.9994	1.0041	0.9612	\$ 960.38	\$ 960.38
08	Monroe	Maternity Kickpayment	Maternity Kickpayment, All Ages	1.0000	1.0000	1.0000	0.9157	\$ 4,827.06	0.0%	\$ 4,827.06	1.0000	1.0000	1.0000	0.9376	\$ 5,097.23	\$ 5,097.23

FOR PROPOSALS

# CCN-P REQUEST FOR PROPOSALS

## Attachment B Rate Development Overview

5/1/2012-12/31/2012

DHH Administrative Region	Region Description	COA Description	RC Description	Weighted FY09 and FY10 PMPM at FY10	Trend	Projected FFS PMPM	MC Savings	PMPM Post-IC Savings	PMPM Post Smoothing w/Statewide	Premium Load	Proposed CCN-P Premium (Gross of GME)	GME Adjustment	Proposed CCN-P Premium (Net of GME)
05	Lake Charles	SSI	0-2 Months, Male and Female	\$ 14,284.65	2.27%	\$ 15,163.56	-20.28%	\$ 12,089.61	\$ 14,467.00	12.7%	\$ 16,574.62	0.9573	\$ 15,866.36
05	Lake Charles	SSI	3-11 Months, Male and Female	\$ 2,264.64	2.99%	\$ 2,443.51	-15.66%	\$ 2,066.03	\$ 2,880.00	12.7%	\$ 3,299.78	0.9573	\$ 3,142.72
05	Lake Charles	SSI	1-5 Years, Male and Female	\$ 539.35	4.69%	\$ 609.43	-8.07%	\$ 560.24	\$ 602.99	12.7%	\$ 676.28	0.9681	\$ 657.89
05	Lake Charles	SSI	6-13 Years, Male and Female	\$ 179.41	4.31%	\$ 200.77	-12.36%	\$ 175.91	\$ 146.23	12.7%	\$ 167.54	0.9671	\$ 163.70
05	Lake Charles	SSI	14-18 Years, Male and Female	\$ 132.88	4.94%	\$ 151.10	-12.14%	\$ 132.75	\$ 152.60	12.7%	\$ 174.83	0.9664	\$ 168.96
05	Lake Charles	SSI	19-44 Years, Male and Female	\$ 329.97	5.02%	\$ 376.04	-16.65%	\$ 313.42	\$ 359.08	12.7%	\$ 399.48	0.9983	\$ 368.48
05	Lake Charles	SSI	45+ Years, Male and Female	\$ 565.84	4.85%	\$ 642.02	-17.11%	\$ 532.16	\$ 609.68	12.7%	\$ 684.48	0.9983	\$ 608.48
05	Lake Charles	Family and Children	0-2 Months, Male and Female	\$ 1,254.88	2.23%	\$ 1,330.80	-24.81%	\$ 1,000.59	\$ 1,146.43	12.7%	\$ 1,414.75	0.9959	\$ 1,141.75
05	Lake Charles	Family and Children	3-11 Months, Male and Female	\$ 174.20	3.68%	\$ 191.84	-11.58%	\$ 169.62	\$ 194.35	12.7%	\$ 217.96	0.9972	\$ 193.82
05	Lake Charles	Family and Children	1-5 Years, Male and Female	\$ 73.53	4.54%	\$ 82.77	-10.25%	\$ 74.29	\$ 85.12	12.7%	\$ 95.07	0.9984	\$ 83.07
05	Lake Charles	Family and Children	6-13 Years, Male and Female	\$ 50.80	4.61%	\$ 57.28	-10.26%	\$ 51.41	\$ 58.90	12.7%	\$ 68.12	0.9984	\$ 58.86
05	Lake Charles	Family and Children	14-18 Years, Female	\$ 83.37	5.00%	\$ 94.95	-12.69%	\$ 82.90	\$ 94.98	12.7%	\$ 109.94	0.9996	\$ 94.94
05	Lake Charles	Family and Children	14-18 Years, Male	\$ 57.41	4.99%	\$ 65.04	-13.99%	\$ 55.94	\$ 64.09	12.7%	\$ 76.24	0.9994	\$ 64.06
05	Lake Charles	Family and Children	19-44 Years, Female	\$ 184.43	4.94%	\$ 209.75	-17.35%	\$ 173.36	\$ 198.62	12.7%	\$ 227.96	0.9985	\$ 198.52
05	Lake Charles	Family and Children	19-44 Years, Male	\$ 167.81	4.95%	\$ 190.91	-19.19%	\$ 154.27	\$ 176.21	12.7%	\$ 200.55	0.9815	\$ 172.96
05	Lake Charles	Family and Children	45+ Years, Female	\$ 281.31	4.39%	\$ 315.47	-19.82%	\$ 282.95	\$ 327.57	12.7%	\$ 368.24	0.9781	\$ 286.24
05	Lake Charles	Family and Children	45+ Years, Male	\$ 394.35	4.45%	\$ 442.96	-20.82%	\$ 350.75	\$ 406.91	12.7%	\$ 489.05	0.9744	\$ 399.05
05	Lake Charles	Foster Care Children	Foster Care, All Ages, Male & Female	\$ 100.54	5.29%	\$ 115.37	-10.56%	\$ 103.18	\$ 113.47	12.7%	\$ 131.39	0.9817	\$ 111.39
05	Lake Charles	Breast and Cervical Cancer	BCC, All Ages, Female	\$ 1,531.53	8.95%	\$ 1,924.79	-17.23%	\$ 1,593.16	\$ 1,749.26	12.7%	\$ 2,082.66	0.9766	\$ 1,708.25
05	Lake Charles	Maternity Kickpayment	Maternity Kickpayment, All Ages	\$ 4,394.07	0.00%	\$ 4,394.07	0.50%	\$ 4,416.04	\$ 4,716.66	6.4%	\$ 5,146.62	0.9984	\$ 4,708.91
06	Alexandria	SSI	0-2 Months, Male and Female	\$ 16,996.41	2.24%	\$ 18,030.02	-19.15%	\$ 14,577.82	\$ 16,574.62	12.7%	\$ 18,866.36	0.9573	\$ 15,866.36
06	Alexandria	SSI	3-11 Months, Male and Female	\$ 3,662.88	2.38%	\$ 3,900.25	-16.85%	\$ 3,165.04	\$ 3,299.78	12.7%	\$ 3,724.72	0.9524	\$ 3,142.72
06	Alexandria	SSI	1-5 Years, Male and Female	\$ 407.56	4.25%	\$ 455.39	-11.76%	\$ 401.72	\$ 452.99	12.7%	\$ 517.28	0.9681	\$ 457.89
06	Alexandria	SSI	6-13 Years, Male and Female	\$ 166.01	4.32%	\$ 185.83	-12.39%	\$ 162.81	\$ 181.70	12.7%	\$ 214.72	0.9671	\$ 163.70
06	Alexandria	SSI	14-18 Years, Male and Female	\$ 135.15	5.33%	\$ 155.24	-13.01%	\$ 135.04	\$ 152.60	12.7%	\$ 174.83	0.9664	\$ 168.96
06	Alexandria	SSI	19-44 Years, Male and Female	\$ 295.66	4.98%	\$ 336.58	-16.75%	\$ 280.20	\$ 321.02	12.7%	\$ 370.66	0.9939	\$ 319.06
06	Alexandria	Family and Children	45+ Years, Male and Female	\$ 541.17	4.64%	\$ 610.74	-16.92%	\$ 507.39	\$ 561.39	12.7%	\$ 648.36	0.9962	\$ 579.07
06	Alexandria	Family and Children	0-2 Months, Male and Female	\$ 1,430.15	2.12%	\$ 1,512.63	-25.21%	\$ 1,131.37	\$ 1,313.27	12.7%	\$ 1,519.27	0.9661	\$ 1,291.22
06	Alexandria	Family and Children	3-11 Months, Male and Female	\$ 82.38	3.75%	\$ 201.19	-12.74%	\$ 175.56	\$ 201.15	12.7%	\$ 230.55	0.9970	\$ 200.55
06	Alexandria	Family and Children	1-5 Years, Male and Female	\$ 83.57	4.42%	\$ 93.78	-11.71%	\$ 82.81	\$ 94.88	12.7%	\$ 109.88	0.9980	\$ 94.88
06	Alexandria	Family and Children	6-13 Years, Male and Female	\$ 51.93	4.67%	\$ 58.65	-10.50%	\$ 52.49	\$ 60.14	12.7%	\$ 70.05	0.9984	\$ 60.05
06	Alexandria	Family and Children	14-18 Years, Female	\$ 87.80	5.03%	\$ 100.08	-13.63%	\$ 86.44	\$ 99.04	12.7%	\$ 116.66	0.9979	\$ 98.83
06	Alexandria	Family and Children	14-18 Years, Male	\$ 60.23	4.95%	\$ 68.50	-14.20%	\$ 58.78	\$ 67.34	12.7%	\$ 79.66	0.9976	\$ 67.18
06	Alexandria	Family and Children	19-44 Years, Female	\$ 175.81	4.92%	\$ 199.86	-18.09%	\$ 163.71	\$ 187.57	12.7%	\$ 219.27	0.9971	\$ 187.02
06	Alexandria	Family and Children	19-44 Years, Male	\$ 175.68	4.94%	\$ 199.77	-19.37%	\$ 161.08	\$ 176.21	12.7%	\$ 204.96	0.9815	\$ 172.96
06	Alexandria	Family and Children	45+ Years, Female	\$ 350.88	4.15%	\$ 391.08	-20.55%	\$ 310.73	\$ 337.57	12.7%	\$ 396.24	0.9781	\$ 268.24
06	Alexandria	Family and Children	45+ Years, Male	\$ 428.81	3.92%	\$ 475.10	-22.44%	\$ 368.48	\$ 426.87	12.7%	\$ 509.05	0.9744	\$ 399.05
06	Alexandria	Foster Care Children	Foster Care, All Ages, Male & Female	\$ 89.51	4.89%	\$ 101.67	-10.14%	\$ 91.36	\$ 99.04	12.7%	\$ 113.47	0.9817	\$ 111.39
06	Alexandria	Breast and Cervical Cancer	BCC, All Ages, Female	\$ 1,615.26	7.54%	\$ 1,960.93	-17.11%	\$ 1,625.35	\$ 1,826.66	12.7%	\$ 2,108.25	0.9766	\$ 1,708.25
06	Alexandria	Maternity Kickpayment	Maternity Kickpayment, All Ages	\$ 4,500.92	0.00%	\$ 4,500.92	0.50%	\$ 4,523.42	\$ 4,831.36	6.4%	\$ 5,266.36	0.9972	\$ 4,817.69
07	Shreveport	SSI	0-2 Months, Male and Female	\$ 13,202.88	2.24%	\$ 14,007.63	-19.05%	\$ 11,338.76	\$ 14,467.00	12.7%	\$ 16,574.62	0.9573	\$ 15,866.36
07	Shreveport	SSI	3-11 Months, Male and Female	\$ 3,720.90	2.69%	\$ 3,994.14	-18.37%	\$ 3,260.46	\$ 3,299.78	12.7%	\$ 3,724.72	0.9524	\$ 3,142.72
07	Shreveport	SSI	1-5 Years, Male and Female	\$ 362.01	4.17%	\$ 403.67	-13.67%	\$ 348.47	\$ 392.99	12.7%	\$ 457.89	0.9681	\$ 407.89
07	Shreveport	SSI	6-13 Years, Male and Female	\$ 128.31	4.91%	\$ 145.81	-12.79%	\$ 127.17	\$ 146.23	12.7%	\$ 174.83	0.9671	\$ 163.70
07	Shreveport	SSI	14-18 Years, Male and Female	\$ 187.55	4.49%	\$ 210.87	-15.92%	\$ 177.31	\$ 194.83	12.7%	\$ 227.96	0.9664	\$ 188.96
07	Shreveport	SSI	19-44 Years, Male and Female	\$ 397.31	4.40%	\$ 445.60	-18.27%	\$ 364.20	\$ 417.26	12.7%	\$ 489.48	0.9973	\$ 417.26
07	Shreveport	SSI	45+ Years, Male and Female	\$ 567.96	4.68%	\$ 664.18	-17.49%	\$ 548.04	\$ 627.87	12.7%	\$ 744.87	0.9460	\$ 593.98
07	Shreveport	Family and Children	0-2 Months, Male and Female	\$ 1,420.40	2.09%	\$ 1,501.10	-25.92%	\$ 1,112.00	\$ 1,274.07	12.7%	\$ 1,474.96	0.9460	\$ 1,177.96
07	Shreveport	Family and Children	3-11 Months, Male and Female	\$ 188.17	3.69%	\$ 207.27	-15.64%	\$ 174.85	\$ 200.33	12.7%	\$ 230.33	0.9627	\$ 192.86
07	Shreveport	Family and Children	1-5 Years, Male and Female	\$ 75.86	4.46%	\$ 85.22	-13.95%	\$ 73.29	\$ 83.97	12.7%	\$ 97.44	0.9734	\$ 81.74
07	Shreveport	Family and Children	6-13 Years, Male and Female	\$ 43.05	4.74%	\$ 49.71	-12.18%	\$ 42.78	\$ 49.02	12.7%	\$ 58.06	0.9805	\$ 48.06
07	Shreveport	Family and Children	14-18 Years, Male and Female	\$ 82.88	5.15%	\$ 94.76	-14.85%	\$ 80.69	\$ 92.45	12.7%	\$ 109.30	0.9768	\$ 90.30
07	Shreveport	Family and Children	19-44 Years, Male	\$ 50.07	5.03%	\$ 57.08	-15.12%	\$ 48.45	\$ 55.51	12.7%	\$ 66.24	0.9772	\$ 54.24
07	Shreveport	Family and Children	19-44 Years, Female	\$ 182.06	4.87%	\$ 206.69	-19.61%	\$ 166.17	\$ 190.38	12.7%	\$ 224.40	0.9633	\$ 183.40
07	Shreveport	Family and Children	19-44 Years, Male	\$ 175.88	4.45%	\$ 197.51	-21.42%	\$ 155.20	\$ 176.21	12.7%	\$ 204.96	0.9815	\$ 172.96
07	Shreveport	Family and Children	45+ Years, Female	\$ 282.85	4.60%	\$ 318.87	-19.86%	\$ 255.94	\$ 272.20	12.7%	\$ 319.24	0.9781	\$ 268.24
07	Shreveport	Family and Children	45+ Years, Male	\$ 319.00	4.49%	\$ 358.66	-20.75%	\$ 284.23	\$ 306.91	12.7%	\$ 360.91	0.9744	\$ 299.05
07	Shreveport	Foster Care Children	Foster Care, All Ages, Male & Female	\$ 96.48	5.04%	\$ 110.00	-12.13%	\$ 96.46	\$ 113.47	12.7%	\$ 131.39	0.9817	\$ 111.39
07	Shreveport	Breast and Cervical Cancer	BCC, All Ages, Female	\$ 1,662.30	8.66%	\$ 2,054.00	-17.17%	\$ 1,701.32	\$ 1,926.66	12.7%	\$ 2,274.26	0.9766	\$ 1,708.25
07	Shreveport	Maternity Kickpayment	Maternity Kickpayment, All Ages	\$ 4,833.32	0.00%	\$ 4,833.32	0.50%	\$ 4,857.48	\$ 5,188.16	6.4%	\$ 5,686.16	0.9988	\$ 5,188.16

# Attachment B Rate Development Overview

5/1/2012-12/31/2012												
DHH Administrative Region	Region Description	COA Description	RC Description	Weighted FY09 and FY10 PMPM at FY10	Trend	Projected FFS PMPM	MC Savings	PMPM Post-IC Savings	PMPM Post Smoothing w/Statewide	Premium Load	Proposed CCN-P Premium (Gross of GME)	Proposed CCN-P Premium (Net of GME)
				PMPM or Cost/Delivery		PMPM or Cost/Delivery	MC Savings	PMPM or Cost/Delivery	PMPM or Cost/Delivery		PMPM or Cost/Delivery	PMPM or Cost/Delivery
08	Monroe	SSI	0-2 Months, Male and Female	\$ 16,447.56	2.24%	\$ 17,447.85	-17.26%	\$ 14,436.62	\$ 14,467.00	12.7%	\$ 16,574.62	\$ 15,866.36
08	Monroe	SSI	3-11 Months, Male and Female	\$ 2,070.40	3.29%	\$ 2,257.21	-13.76%	\$ 1,946.16	\$ 2,880.16	12.7%	\$ 3,299.78	\$ 3,142.72
08	Monroe	SSI	1-5 Years, Male and Female	\$ 656.03	3.88%	\$ 726.10	-11.40%	\$ 643.33	\$ 502.99	12.7%	\$ 576.28	\$ 557.89
08	Monroe	SSI	6-13 Years, Male and Female	\$ 184.03	4.25%	\$ 205.64	-12.30%	\$ 150.35	\$ 146.23	12.7%	\$ 167.54	\$ 163.70
08	Monroe	SSI	14-18 Years, Male and Female	\$ 161.74	4.90%	\$ 183.74	-13.72%	\$ 158.52	\$ 152.60	12.7%	\$ 174.83	\$ 168.96
08	Monroe	SSI	19-44 Years, Male and Female	\$ 315.43	4.65%	\$ 356.10	-17.13%	\$ 295.10	\$ 295.10	12.7%	\$ 338.09	\$ 334.96
08	Monroe	SSI	45+ Years, Male and Female	\$ 565.03	4.67%	\$ 638.11	-16.63%	\$ 532.01	\$ 532.01	12.7%	\$ 609.51	\$ 603.78
08	Monroe	Family and Children	0-2 Months, Male and Female	\$ 1,460.72	2.17%	\$ 1,548.80	-23.02%	\$ 1,190.67	\$ 1,190.67	12.7%	\$ 1,364.21	\$ 1,347.66
08	Monroe	Family and Children	3-11 Months, Male and Female	\$ 198.61	3.61%	\$ 218.29	-13.56%	\$ 188.70	\$ 188.70	12.7%	\$ 216.21	\$ 214.86
08	Monroe	Family and Children	1-5 Years, Male and Female	\$ 81.06	4.44%	\$ 91.03	-11.19%	\$ 80.84	\$ 80.84	12.7%	\$ 92.62	\$ 92.22
08	Monroe	Family and Children	6-13 Years, Male and Female	\$ 49.15	4.56%	\$ 55.36	-10.09%	\$ 49.78	\$ 49.78	12.7%	\$ 57.04	\$ 56.83
08	Monroe	Family and Children	14-18 Years, Female	\$ 85.96	4.79%	\$ 97.38	-12.51%	\$ 85.20	\$ 85.20	12.7%	\$ 97.61	\$ 97.20
08	Monroe	Family and Children	19-44 Years, Male	\$ 59.89	4.79%	\$ 67.85	-14.15%	\$ 58.24	\$ 58.24	12.7%	\$ 66.73	\$ 66.40
08	Monroe	Family and Children	19-44 Years, Female	\$ 159.88	4.75%	\$ 180.95	-17.80%	\$ 148.74	\$ 148.74	12.7%	\$ 170.41	\$ 169.34
08	Monroe	Family and Children	19-44 Years, Male	\$ 170.67	4.79%	\$ 193.36	-19.02%	\$ 156.58	\$ 153.80	12.7%	\$ 176.21	\$ 172.96
08	Monroe	Family and Children	45+ Years, Female	\$ 289.30	4.48%	\$ 323.19	-19.11%	\$ 263.06	\$ 237.57	12.7%	\$ 272.20	\$ 268.24
08	Monroe	Family and Children	45+ Years, Male	\$ 351.40	3.77%	\$ 387.82	-22.65%	\$ 299.88	\$ 267.87	12.7%	\$ 306.91	\$ 299.05
08	Monroe	Foster Care Children	Foster Care, All Ages, Male & Female	\$ 81.46	5.36%	\$ 93.64	-8.88%	\$ 85.33	\$ 99.04	12.7%	\$ 113.47	\$ 111.39
08	Monroe	Breast and Cervical Cancer	BCC, All Ages, Female	\$ 1,091.34	8.06%	\$ 1,342.01	-16.71%	\$ 1,117.80	\$ 1,526.93	12.7%	\$ 1,749.26	\$ 1,708.25
08	Monroe	Maternity Kickpayment	Maternity Kickpayment, All Ages	\$ 4,989.16	0.00%	\$ 4,989.16	0.50%	\$ 5,014.11	\$ 5,014.11	6.4%	\$ 5,355.44	\$ 5,354.54

Attachment C  
Family Planning Rate Overview

DHH Administrative Region		Region Description	COA Description	RC Description	PMPM Post Smoothing w/Statewide	FY10 Family Planning Percentage	Family Planning PMPM
01	New Orleans	SSI	Family and Children	0-2 Months, Male and Female	\$ 14,412.67	0.0%	\$ -
01	New Orleans	SSI	Family and Children	3-11 Months, Male and Female	\$ 2,866.60	0.0%	\$ -
01	New Orleans	SSI	Family and Children	1-5 Years, Male and Female	\$ 499.56	0.0%	\$ -
01	New Orleans	SSI	Family and Children	6-13 Years, Male and Female	\$ 145.12	0.0%	\$ 0.05
01	New Orleans	SSI	Family and Children	14-18 Years, Male and Female	\$ 151.41	0.9%	\$ 1.43
01	New Orleans	SSI	Family and Children	19-44 Years, Male and Female	\$ 388.93	0.3%	\$ 1.34
01	New Orleans	SSI	Family and Children	45+ Years, Male and Female	\$ 611.57	0.0%	\$ 0.10
01	New Orleans	Family and Children	Family and Children	0-2 Months, Male and Female	\$ 991.94	0.0%	\$ -
01	New Orleans	Family and Children	Family and Children	3-11 Months, Male and Female	\$ 147.19	0.0%	\$ -
01	New Orleans	Family and Children	Family and Children	1-5 Years, Male and Female	\$ 62.83	0.0%	\$ -
01	New Orleans	Family and Children	Family and Children	6-13 Years, Male and Female	\$ 39.45	0.1%	\$ 0.03
01	New Orleans	Family and Children	Family and Children	14-18 Years, Female	\$ 63.39	4.9%	\$ 3.10
01	New Orleans	Family and Children	Family and Children	14-18 Years, Male	\$ 46.87	0.0%	\$ 0.02
01	New Orleans	Family and Children	Family and Children	19-44 Years, Female	\$ 137.86	4.9%	\$ 6.74
01	New Orleans	Family and Children	Family and Children	19-44 Years, Male	\$ 152.60	0.0%	\$ 0.04
01	New Orleans	Family and Children	Family and Children	45+ Years, Female	\$ 235.77	0.4%	\$ 0.99
01	New Orleans	Family and Children	Family and Children	45+ Years, Male	\$ 265.95	0.0%	\$ -
01	New Orleans	Foster Care Children	Foster Care Children	Foster Care, All Ages Male & Female	\$ 98.25	0.5%	\$ 0.51
01	New Orleans	Breast and Cervical Cancer Maternity Kickpayment	Breast and Cervical Cancer Maternity Kickpayment	BCC, All Ages Female	\$ 1,506.44	0.0%	\$ 0.27
01	New Orleans	Breast and Cervical Cancer Maternity Kickpayment	Breast and Cervical Cancer Maternity Kickpayment	Maternity Kickpayment, All Ages	\$ 6,447.57	0.1%	\$ 3.50
09	Mandeville	SSI	Family and Children	0-2 Months, Male and Female	\$ 14,412.67	0.0%	\$ -
09	Mandeville	SSI	Family and Children	3-11 Months, Male and Female	\$ 2,866.60	0.0%	\$ -
09	Mandeville	SSI	Family and Children	1-5 Years, Male and Female	\$ 499.56	0.0%	\$ -
09	Mandeville	SSI	Family and Children	6-13 Years, Male and Female	\$ 145.12	0.0%	\$ 0.05
09	Mandeville	SSI	Family and Children	14-18 Years, Male and Female	\$ 151.41	1.0%	\$ 1.47
09	Mandeville	SSI	Family and Children	19-44 Years, Male and Female	\$ 344.62	0.5%	\$ 1.65
09	Mandeville	SSI	Family and Children	45+ Years, Male and Female	\$ 573.74	0.0%	\$ 0.11
09	Mandeville	Family and Children	Family and Children	0-2 Months, Male and Female	\$ 918.79	0.0%	\$ -
09	Mandeville	Family and Children	Family and Children	3-11 Months, Male and Female	\$ 162.13	0.0%	\$ -
09	Mandeville	Family and Children	Family and Children	1-5 Years, Male and Female	\$ 76.02	0.0%	\$ -
09	Mandeville	Family and Children	Family and Children	6-13 Years, Male and Female	\$ 52.62	0.1%	\$ 0.06
09	Mandeville	Family and Children	Family and Children	14-18 Years, Female	\$ 82.34	5.9%	\$ 4.90
09	Mandeville	Family and Children	Family and Children	14-18 Years, Male	\$ 58.38	0.0%	\$ 0.00
09	Mandeville	Family and Children	Family and Children	19-44 Years, Female	\$ 168.55	5.2%	\$ 8.73
09	Mandeville	Family and Children	Family and Children	19-44 Years, Male	\$ 152.60	0.0%	\$ -
09	Mandeville	Family and Children	Family and Children	45+ Years, Female	\$ 235.77	0.3%	\$ 0.77
09	Mandeville	Family and Children	Family and Children	45+ Years, Male	\$ 265.95	0.0%	\$ -
09	Mandeville	Foster Care Children	Foster Care Children	Foster Care, All Ages Male & Female	\$ 98.25	0.7%	\$ 0.70
09	Mandeville	Breast and Cervical Cancer Maternity Kickpayment	Breast and Cervical Cancer Maternity Kickpayment	BCC, All Ages Female	\$ 1,506.44	0.2%	\$ 3.48
09	Mandeville	Breast and Cervical Cancer Maternity Kickpayment	Breast and Cervical Cancer Maternity Kickpayment	Maternity Kickpayment, All Ages	\$ 4,687.28	0.1%	\$ 5.94

# Attachment C Family Planning Rate Overview

		3/1/2012-12/31/2012				
DHH Administrative Region	Region Description	COA Description	RC Description	PMPM Post Smoothing w/Statewide	FY10 Family Planning Percentage	Family Planning PMPM
02	Baton Rouge	SSI	0-2 Months, Male and Female	\$ 14,439.80	0.0%	\$ -
02	Baton Rouge	SSI	3-11 Months, Male and Female	\$ 2,873.37	0.0%	\$ -
02	Baton Rouge	SSI	1-5 Years, Male and Female	\$ 501.27	0.0%	\$ -
02	Baton Rouge	SSI	6-13 Years, Male and Female	\$ 145.67	0.0%	\$ 0.07
02	Baton Rouge	SSI	14-18 Years, Male and Female	\$ 152.00	1.1%	\$ 1.62
02	Baton Rouge	SSI	19-44 Years, Male and Female	\$ 393.76	0.3%	\$ 1.04
02	Baton Rouge	SSI	45+ Years, Male and Female	\$ 553.93	0.0%	\$ 0.12
02	Baton Rouge	Family and Children	0-2 Months, Male and Female	\$ 1,016.45	0.0%	\$ -
02	Baton Rouge	Family and Children	3-11 Months, Male and Female	\$ 156.81	0.0%	\$ -
02	Baton Rouge	Family and Children	1-5 Years, Male and Female	\$ 61.44	0.0%	\$ -
02	Baton Rouge	Family and Children	6-13 Years, Male and Female	\$ 38.86	0.1%	\$ 0.04
02	Baton Rouge	Family and Children	14-18 Years, Female	\$ 65.70	5.4%	\$ 3.57
02	Baton Rouge	Family and Children	14-18 Years, Male	\$ 46.12	0.0%	\$ 0.01
02	Baton Rouge	Family and Children	19-44 Years, Female	\$ 138.60	4.1%	\$ 5.69
02	Baton Rouge	Family and Children	19-44 Years, Male	\$ 153.20	0.0%	\$ -
02	Baton Rouge	Family and Children	45+ Years, Female	\$ 236.67	0.1%	\$ 0.20
02	Baton Rouge	Family and Children	45+ Years, Male	\$ 266.91	0.0%	\$ 0.02
02	Baton Rouge	Foster Care Children	Foster Care, All Ages Male & Female	\$ 98.64	1.3%	\$ 1.27
02	Baton Rouge	Breast and Cervical Cancer	BCC, All Ages Female	\$ 1,516.64	0.1%	\$ 4.97
02	Baton Rouge	Maternity Kickpayment	Maternity Kickpayment, All Ages	\$ 4,902.05	0.1%	\$ 4.97
03	Thibodaux	SSI	0-2 Months, Male and Female	\$ 14,439.80	0.0%	\$ -
03	Thibodaux	SSI	3-11 Months, Male and Female	\$ 2,873.37	0.0%	\$ -
03	Thibodaux	SSI	1-5 Years, Male and Female	\$ 501.27	0.0%	\$ -
03	Thibodaux	SSI	6-13 Years, Male and Female	\$ 145.67	0.1%	\$ 0.08
03	Thibodaux	SSI	14-18 Years, Male and Female	\$ 152.00	1.4%	\$ 2.08
03	Thibodaux	SSI	19-44 Years, Male and Female	\$ 303.08	0.7%	\$ 2.01
03	Thibodaux	SSI	45+ Years, Male and Female	\$ 547.81	0.0%	\$ 0.14
03	Thibodaux	Family and Children	0-2 Months, Male and Female	\$ 878.80	0.0%	\$ -
03	Thibodaux	Family and Children	3-11 Months, Male and Female	\$ 160.15	0.0%	\$ 0.00
03	Thibodaux	Family and Children	1-5 Years, Male and Female	\$ 74.50	0.0%	\$ -
03	Thibodaux	Family and Children	6-13 Years, Male and Female	\$ 49.99	0.1%	\$ 0.06
03	Thibodaux	Family and Children	14-18 Years, Female	\$ 90.58	6.2%	\$ 5.60
03	Thibodaux	Family and Children	14-18 Years, Male	\$ 60.23	0.0%	\$ 0.01
03	Thibodaux	Family and Children	19-44 Years, Female	\$ 174.88	5.6%	\$ 9.77
03	Thibodaux	Family and Children	19-44 Years, Male	\$ 153.20	0.0%	\$ -
03	Thibodaux	Family and Children	45+ Years, Female	\$ 236.67	0.2%	\$ 0.49
03	Thibodaux	Family and Children	45+ Years, Male	\$ 266.91	0.0%	\$ -
03	Thibodaux	Foster Care Children	Foster Care, All Ages Male & Female	\$ 98.64	1.3%	\$ 1.32
03	Thibodaux	Breast and Cervical Cancer	BCC, All Ages Female	\$ 1,516.64	0.0%	\$ -
03	Thibodaux	Maternity Kickpayment	Maternity Kickpayment, All Ages	\$ 4,855.54	0.1%	\$ 4.41

Attachment C  
Family Planning Rate Overview

		3/1/2012-12/31/2012				
DHH Administrative Region	Region Description	COA Description	RC Description	PMPM Post Smoothing w/Statewide	FY10 Family Planning Percentage	Family Planning PMPM
04	LaFayette	SSI	0-2 Months, Male and Female	\$ 14,439.80	0.0%	\$ -
04	LaFayette	SSI	3-11 Months, Male and Female	\$ 2,873.37	0.0%	\$ -
04	LaFayette	SSI	1-5 Years, Male and Female	\$ 501.27	0.0%	\$ -
04	LaFayette	SSI	6-13 Years, Male and Female	\$ 145.67	0.0%	\$ 0.03
04	LaFayette	SSI	14-18 Years, Male and Female	\$ 152.00	0.9%	\$ 1.32
04	LaFayette	SSI	19-44 Years, Male and Female	\$ 330.37	0.3%	\$ 0.98
04	LaFayette	SSI	45+ Years, Male and Female	\$ 495.64	0.0%	\$ 0.04
04	LaFayette	Family and Children	0-2 Months, Male and Female	\$ 1,014.08	0.0%	\$ -
04	LaFayette	Family and Children	3-11 Months, Male and Female	\$ 169.39	0.0%	\$ -
04	LaFayette	Family and Children	1-5 Years, Male and Female	\$ 69.33	0.0%	\$ -
04	LaFayette	Family and Children	6-13 Years, Male and Female	\$ 45.49	0.1%	\$ 0.04
04	LaFayette	Family and Children	14-18 Years, Female	\$ 73.63	4.2%	\$ 3.07
04	LaFayette	Family and Children	14-18 Years, Male	\$ 50.83	0.0%	\$ -
04	LaFayette	Family and Children	19-44 Years, Female	\$ 148.44	4.5%	\$ 6.61
04	LaFayette	Family and Children	19-44 Years, Male	\$ 153.20	0.0%	\$ -
04	LaFayette	Family and Children	45+ Years, Female	\$ 236.67	0.3%	\$ 0.63
04	LaFayette	Family and Children	45+ Years, Male	\$ 266.91	0.0%	\$ -
04	LaFayette	Foster Care Children	Foster Care, All Ages Male & Female	\$ 98.64	0.6%	\$ 0.64
04	LaFayette	Breast and Cervical Cancer	BCC, All Ages Female	\$ 1,516.64	0.1%	\$ 0.88
04	LaFayette	Maternity Kickpayment	Maternity Kickpayment, All Ages	\$ 4,265.38	0.1%	\$ 3.59

Attachment C  
Family Planning Rate Overview

DHH Administrative Region		Region Description	COA Description	RC Description	PMPM Post Smoothing w/Statewide	FY10 Family Planning Percentage	Family Planning PMPM
05	Lake Charles	SSI		0-2 Months, Male and Female	\$ 14,467.00	0.0%	\$ -
05	Lake Charles	SSI		3-11 Months, Male and Female	\$ 2,880.16	0.0%	\$ -
05	Lake Charles	SSI		1-5 Years, Male and Female	\$ 502.99	0.0%	\$ -
05	Lake Charles	SSI		6-13 Years, Male and Female	\$ 146.23	0.0%	\$ 0.03
05	Lake Charles	SSI		14-18 Years, Male and Female	\$ 152.60	1.1%	\$ 1.74
05	Lake Charles	SSI		19-44 Years, Male and Female	\$ 313.42	0.5%	\$ 1.52
05	Lake Charles	SSI		45+ Years, Male and Female	\$ 532.16	0.0%	\$ 0.04
05	Lake Charles	Family and Children		0-2 Months, Male and Female	\$ 1,000.59	0.0%	\$ -
05	Lake Charles	Family and Children		3-11 Months, Male and Female	\$ 169.62	0.0%	\$ -
05	Lake Charles	Family and Children		1-5 Years, Male and Female	\$ 74.29	0.0%	\$ -
05	Lake Charles	Family and Children		6-13 Years, Male and Female	\$ 51.41	0.1%	\$ 0.05
05	Lake Charles	Family and Children		14-18 Years, Female	\$ 82.90	5.0%	\$ 4.11
05	Lake Charles	Family and Children		14-18 Years, Male	\$ 55.94	0.0%	\$ 0.02
05	Lake Charles	Family and Children		19-44 Years, Female	\$ 173.36	5.8%	\$ 10.00
05	Lake Charles	Family and Children		19-44 Years, Male	\$ 153.80	0.0%	\$ 0.04
05	Lake Charles	Family and Children		45+ Years, Female	\$ 237.57	0.1%	\$ 0.22
05	Lake Charles	Family and Children		45+ Years, Male	\$ 267.87	0.0%	\$ -
05	Lake Charles	Foster Care Children		Foster Care, All Ages Male & Female	\$ 99.04	0.3%	\$ 0.34
05	Lake Charles	Breast and Cervical Cancer		BCC, All Ages Female	\$ 1,526.93	0.1%	\$ 0.85
05	Lake Charles	Maternity Kickpayment		Maternity Kickpayment, All Ages	\$ 4,416.04	0.3%	\$ 14.41
06	Alexandria	SSI		0-2 Months, Male and Female	\$ 14,467.00	0.0%	\$ -
06	Alexandria	SSI		3-11 Months, Male and Female	\$ 2,880.16	0.0%	\$ -
06	Alexandria	SSI		1-5 Years, Male and Female	\$ 502.99	0.0%	\$ -
06	Alexandria	SSI		6-13 Years, Male and Female	\$ 146.23	0.0%	\$ 0.06
06	Alexandria	SSI		14-18 Years, Male and Female	\$ 152.60	1.3%	\$ 1.97
06	Alexandria	SSI		19-44 Years, Male and Female	\$ 280.20	0.4%	\$ 1.25
06	Alexandria	SSI		45+ Years, Male and Female	\$ 507.39	0.0%	\$ 0.03
06	Alexandria	Family and Children		0-2 Months, Male and Female	\$ 1,131.37	0.0%	\$ -
06	Alexandria	Family and Children		3-11 Months, Male and Female	\$ 175.56	0.0%	\$ -
06	Alexandria	Family and Children		1-5 Years, Male and Female	\$ 82.81	0.0%	\$ -
06	Alexandria	Family and Children		6-13 Years, Male and Female	\$ 52.49	0.1%	\$ 0.06
06	Alexandria	Family and Children		14-18 Years, Female	\$ 86.44	5.1%	\$ 4.40
06	Alexandria	Family and Children		14-18 Years, Male	\$ 58.78	0.0%	\$ 0.00
06	Alexandria	Family and Children		19-44 Years, Female	\$ 163.71	5.6%	\$ 9.09
06	Alexandria	Family and Children		19-44 Years, Male	\$ 153.80	0.0%	\$ -
06	Alexandria	Family and Children		45+ Years, Female	\$ 237.57	0.1%	\$ 0.14
06	Alexandria	Family and Children		45+ Years, Male	\$ 267.87	0.0%	\$ -
06	Alexandria	Foster Care Children		Foster Care, All Ages Male & Female	\$ 99.04	0.8%	\$ 0.81
06	Alexandria	Breast and Cervical Cancer		BCC, All Ages Female	\$ 1,526.93	0.0%	\$ 0.06
06	Alexandria	Maternity Kickpayment		Maternity Kickpayment, All Ages	\$ 4,523.42	0.0%	\$ 1.64

Attachment C  
Family Planning Rate Overview

DHH Administrative Region		Region Description	COA Description	RC Description	PMPM Post Smoothing w/Statewide	FY10 Family Planning Percentage	Family Planning PMPM
07	Shreveport	SSI		0-2 Months, Male and Female	\$ 14,467.00	0.0%	\$ -
07	Shreveport	SSI		3-11 Months, Male and Female	\$ 2,880.16	0.0%	\$ -
07	Shreveport	SSI		1-5 Years, Male and Female	\$ 502.99	0.0%	\$ -
07	Shreveport	SSI		6-13 Years, Male and Female	\$ 146.23	0.1%	\$ 0.12
07	Shreveport	SSI		14-18 Years, Male and Female	\$ 152.60	1.1%	\$ 1.66
07	Shreveport	SSI		19-44 Years, Male and Female	\$ 364.20	0.4%	\$ 1.62
07	Shreveport	SSI		45+ Years, Male and Female	\$ 548.04	0.0%	\$ 0.11
07	Shreveport	Family and Children	Family and Children	0-2 Months, Male and Female	\$ 1,112.00	0.0%	\$ -
07	Shreveport	Family and Children	Family and Children	3-11 Months, Male and Female	\$ 174.85	0.0%	\$ -
07	Shreveport	Family and Children	Family and Children	1-5 Years, Male and Female	\$ 73.29	0.0%	\$ -
07	Shreveport	Family and Children	Family and Children	6-13 Years, Male and Female	\$ 42.78	0.2%	\$ 0.07
07	Shreveport	Family and Children	Family and Children	14-18 Years, Female	\$ 80.69	6.2%	\$ 5.01
07	Shreveport	Family and Children	Family and Children	14-18 Years, Male	\$ 48.45	0.0%	\$ 0.02
07	Shreveport	Family and Children	Family and Children	19-44 Years, Female	\$ 166.17	4.8%	\$ 8.01
07	Shreveport	Family and Children	Family and Children	19-44 Years, Male	\$ 153.80	0.0%	\$ -
07	Shreveport	Family and Children	Family and Children	45+ Years, Female	\$ 237.57	0.2%	\$ 0.57
07	Shreveport	Family and Children	Family and Children	45+ Years, Male	\$ 267.87	0.2%	\$ 0.54
07	Shreveport	Foster Care Children	Foster Care Children	Foster Care, All Ages Male & Female	\$ 99.04	1.5%	\$ 1.47
07	Shreveport	Breast and Cervical Cancer	Breast and Cervical Cancer	BCC, All Ages Female	\$ 1,526.93	0.0%	\$ 0.08
07	Shreveport	Maternity Kickpayment	Maternity Kickpayment	Maternity Kickpayment, All Ages	\$ 4,857.48	0.1%	\$ 3.35
08	Monroe	SSI		0-2 Months, Male and Female	\$ 14,467.00	0.0%	\$ -
08	Monroe	SSI		3-11 Months, Male and Female	\$ 2,880.16	0.0%	\$ -
08	Monroe	SSI		1-5 Years, Male and Female	\$ 502.99	0.0%	\$ -
08	Monroe	SSI		6-13 Years, Male and Female	\$ 146.23	0.1%	\$ 0.11
08	Monroe	SSI		14-18 Years, Male and Female	\$ 152.60	1.4%	\$ 2.21
08	Monroe	SSI		19-44 Years, Male and Female	\$ 295.10	0.6%	\$ 1.68
08	Monroe	SSI		45+ Years, Male and Female	\$ 532.01	0.0%	\$ 0.06
08	Monroe	Family and Children	Family and Children	0-2 Months, Male and Female	\$ 1,190.67	0.0%	\$ -
08	Monroe	Family and Children	Family and Children	3-11 Months, Male and Female	\$ 188.70	0.0%	\$ -
08	Monroe	Family and Children	Family and Children	1-5 Years, Male and Female	\$ 80.84	0.0%	\$ -
08	Monroe	Family and Children	Family and Children	6-13 Years, Male and Female	\$ 49.78	0.2%	\$ 0.10
08	Monroe	Family and Children	Family and Children	14-18 Years, Female	\$ 85.20	6.8%	\$ 5.78
08	Monroe	Family and Children	Family and Children	14-18 Years, Male	\$ 58.24	0.0%	\$ 0.00
08	Monroe	Family and Children	Family and Children	19-44 Years, Female	\$ 148.74	4.9%	\$ 7.33
08	Monroe	Family and Children	Family and Children	19-44 Years, Male	\$ 153.80	0.0%	\$ -
08	Monroe	Family and Children	Family and Children	45+ Years, Female	\$ 237.57	0.2%	\$ 0.57
08	Monroe	Family and Children	Family and Children	45+ Years, Male	\$ 267.87	0.0%	\$ -
08	Monroe	Foster Care Children	Foster Care Children	Foster Care, All Ages Male & Female	\$ 99.04	1.5%	\$ 1.46
08	Monroe	Breast and Cervical Cancer	Breast and Cervical Cancer	BCC, All Ages Female	\$ 1,526.93	0.2%	\$ 3.72
08	Monroe	Maternity Kickpayment	Maternity Kickpayment	Maternity Kickpayment, All Ages	\$ 5,014.11	0.1%	\$ 2.59

## **Appendix H**

# **Medical Loss Ratio Calculation Methodology**

## Medical Loss Ratio (MLR) Requirements

Coordinated Care Networks (CCNs) that receive capitation payments to provide core benefits and services to Louisiana Medicaid members are required to rebate a portion of the capitation payment to DHH in the event the CCN does not meet the eighty five percentage (85%) MLR standard. This document describes requirements for 1) reporting MLR, 2) methodology for calculation of MLR, 3) record retention 4) payment of any rebate due DHH, and 4) monetary penalties that may be assessed against the CCN for failure to meet requirements.

### Definitions

**Direct Paid Claims** - claim payments before ceded reinsurance and excluding assumed reinsurance except as otherwise provided in this Appendix.

**MLR Reporting Year** - calendar year during which core benefits and services are provided to Louisiana Medicaid members through contract with DHH.

**Unpaid Claim Reserves** - reserves and liabilities established to account for claims that were incurred during the MLR reporting year but had not been paid within 3 months of the end of the MLR reporting year.

### Reporting Requirements

#### A. **General Requirements**

For each MLR reporting year, the CCN must submit to DHH a report which complies with the requirements that follow concerning capitation payments received and expenses related to Louisiana Medicaid enrollees (referred to hereafter as MLR Report).

#### B. **Timing and Form of Report**

The report for each MLR reporting year must be submitted to DHH by June 1 of the year following the end of an MLR reporting year, on a form and in the manner prescribed by DHH.

#### C. **Newer Experience**

If 50 percent or more of the total capitation payment received in an MLR reporting year is attributable to new Medicaid enrollees with less than 12 months of experience in that MLR reporting year, then the experience of these enrollees may be excluded from the MLR Report. If the CCN chooses to defer reporting of newer business, then the excluded experience must be added to the experience reported in the following MLR reporting year.

#### D. **Capitation Payments**

A CCN must report to DHH the total capitation payments received from Louisiana Medicaid for each MLR reporting year. Total capitation payments means all monies paid by DHH to the CCN for providing core benefits and services as defined in the terms of the contract.

### Reimbursement for Clinical Services Provided to Enrollees

#### A. **General Requirements**

The MLR Report must include direct claims paid to or received by providers, whose services are covered by the subcontract for clinical services or supplies covered by DHH's contract with the CCN. Reimbursement for clinical services as defined in this section is referred to as "incurred claims."

B. **Incurred Claims** must include changes in unpaid claims between the prior year's and the current year's unpaid claims reserves, including claims reported in the process of adjustment, percentage withholds from payments made to subcontracted providers, claims that are recoverable for anticipated coordination of benefits (COB), and claim recoveries received as a result of subrogation.

C. Incurred claims must include the change in claims incurred but not reported from the prior year to the current year. Except where inapplicable, the reserve should be based on past experience, and modified to reflect current conditions such as changes in exposure, claim frequency or severity.

D. Incurred claims must include changes in other claims-related reserves.

E. Incurred claims must exclude rebates paid to DHH based upon prior MLR reporting year experience.

F. Adjustments to incurred claims:

1. Adjustments that must be deducted from incurred claims:

- a. Prescription drug rebates received by the CCN
- b. Overpayment recoveries received from providers

2. Adjustments that may be **included** in incurred claims:

- a. The amount of incentive and bonus payments made to providers

3. Adjustments that must not be included in incurred claims:

- a. Amounts paid to third party vendors for secondary network savings
- b. Amounts paid to third party vendors for network development administrative fees, claims processing, and utilization management
- c. Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee. For example, medical record copying costs, attorneys' fees, subrogation vendor fees, compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel and medical record clerks must not be included in incurred claims.

**Activities that Improve Health Care Quality**

**A. General Requirements**

The MLR may include expenditures for activities that improve health care quality, as described in this section.

**B. Activity Requirements**

Activities conducted by a CCN to improve quality must meet the following requirements:

1. The activity must be designed to:
  - a. Improve health quality;
  - b. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;
  - c. Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees;
  - d. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations;
  - e. Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations:
    1. Examples include the direct interaction of the CCN (including those services delegated by subcontract for which the CCN retains ultimate responsibility under the terms of the contract with DHH) with providers and the enrollee or the enrollee's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as:
      - (a) Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives including through the use of the medical homes model as defined in the RFP and contract;
      - (b) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;
      - (c) Quality reporting and documentation of care in non-electronic format;
      - (d) Health information technology to support these activities;

## CCN-P REQUEST FOR PROPOSALS

- f. Accreditation fees directly related to quality of care activities;
- g. Prevent hospital readmissions through a comprehensive program for hospital discharge;
  - 1. Examples include:
    - (a) Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;
    - (b) Patient-centered education and counseling;
    - (c) Personalized post-discharge reinforcement and counseling by an appropriate health care professional;
    - (d) Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission; and,
    - (e) Health information technology to support these activities.
- h. Improve patient safety, reduce medical errors, and lower infection and mortality rates.
  - 1. Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include:
    - (a) The appropriate identification and use of best clinical practices to avoid harm;
    - (b) Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns;
    - (c) Activities to lower the risk of facility-acquired infections;
    - (d) Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions;
    - (e) Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; and,
    - (f) Health information technology to support these activities.
- i. Implement, promote, and increase wellness and health activities:
  - 1. Examples of activities primarily designed to implement, promote, and increase wellness and health activities, include:
    - (a) Wellness assessments;

## CCN-P REQUEST FOR PROPOSALS

- (b) Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
  - (c) Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
  - (d) Public health education campaigns that are performed in conjunction with the Louisiana Office of Public Health ;
  - (e) Actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs), that are not already reflected in payments or claims;
  - (f) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;
  - (g) Coaching or education programs and health promotion activities designed to change member behavior and conditions (for example, smoking or obesity); and,
  - (h) Health information technology to support these activities.
- j. Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology.

### C. Exclusions

1. Expenditures and activities that **must not be included** in quality improving activities are:
  - a. Those that are designed primarily to control or contain costs;
  - b. The *pro rata* share of expenses that are for lines of business or products other than Louisiana Medicaid;
  - c. Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from DHH capitation payments;
  - d. Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;
  - e. Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (for example, costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, including the new ICD-10 requirements);
  - f. That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;
  - g. All retrospective and concurrent utilization review;
  - h. Fraud prevention activities, other than fraud detection/recovery expenses up to the amount recovered that reduces incurred claims;

## CCN-P REQUEST FOR PROPOSALS

- i. The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;
- j. Provider credentialing;
- k. Marketing expenses;
- l. Costs associated with calculating and administering individual enrollee or employee incentives;
- m. That portion of prospective utilization that does not meet the definition of activities that improve health quality;
- n. State and federal taxes and regulatory fees; and,
- o. Any function or activity not expressly included in paragraph (c) of this section, unless otherwise approved by and within the discretion of DHH, upon adequate showing by the CCN that the activity's costs support the definitions and purposes described above or otherwise support monitoring, measuring or reporting health care quality improvement.

### **Expenditures Related to Health Information Technology and Meaningful Use Requirements**

#### **A. General Requirements**

A CCN may include as activities that improve health care quality such Health Information Technology (HIT) expenses as are required to accomplish the activities that are designed for use by the CCN, CCN providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with HHS meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

1. Making incentive payments to health care providers for the adoption of certified electronic health record technologies and their "meaningful use" as defined by HHS to the extent such payments are not included in reimbursement for clinical services;
2. Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicaid incentive payments;
3. Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;
4. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA, URAC, or JHACO, or costs for reporting to DHH on quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures);
5. Reserved;
6. Advancing the ability of enrollees, providers, CCNs or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic Health

## CCN-P REQUEST FOR PROPOSALS

Records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history and to support care management;

7. Reformating, transmitting or reporting data to national or international government-based health organizations, as may be required by DHH, for the purposes of identifying or treating specific conditions or controlling the spread of disease; and,
8. Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

### **Other Non-Claims Costs**

#### **A. General Requirements**

The MLR Report must include non-claims costs described in paragraph B of this section and must provide an explanation of how capitation payments are used, other than to provide reimbursement for clinical services included in core benefits and services, expenditures for activities that improve health care quality, and expenditures related to Health Information Technology and meaningful use requirements.

#### **B. Non-Claims Costs Other**

1. The MLR Report must include any expenses for administrative services that do not constitute adjustments to capitation for clinical services to enrollees, or expenditures on quality improvement activities as defined above.
2. Expenses for administrative services include the following:
  - a. Cost-containment expenses not included as an expenditure related to a qualifying quality activity;
  - b. Loss adjustment expenses not classified as a cost containment expense;
  - c. Workforce salaries and benefits;
  - d. General and administrative expenses; and,
  - e. Community benefit expenditures.

### **Allocation of Expenses**

#### **A. General Requirements**

Each expense must be reported under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit lines of business other than Louisiana Medicaid must be reported on a pro rata share.

#### **B. Description of the Methods Used to Allocate Expenses**

The report required must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, and other non-claims costs resulting from CCN activities in Louisiana. A detailed description of each expense element must be provided, including how each

## CCN-P REQUEST FOR PROPOSALS

specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated.

1. Allocation to each category should be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories above will generally be the most accurate method. If a specific identification is not feasible, the CCN must provide an explanation of why it believes the more accurate result will be gained from allocation of expenses based upon pertinent factors or ratios such as studies of employee activities, salary ratios or similar analyses;
2. Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, must be apportioned *pro rata* to the entities incurring the expense; and,
3. Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, capitation payment ratios or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

### C. Maintenance of Records

The CCN must maintain and make available to DHH upon request the data used to allocate expenses reported, together with all supporting information required to determine that the methods identified and reported as required under paragraph (b) of this section were accurately implemented in preparing the MLR Report.

## Formula for Calculating Medical Loss Ratio

### A. Medical Loss Ratio

1. A CCN's MLR is the ratio of the numerator, as defined in paragraph "a" of this section, to the denominator, as defined in paragraph "b" of this section.
2. A CCN's MLR shall be rounded to three decimal places. For example, if an MLR is 0.7988, it shall be rounded to 0.799 or 79.9 percent. If an MLR is 0.8253 or 82.53 percent, it shall be rounded to 0.825 or 82.5 percent.
  - a. The **numerator** of a CCN's MLR for an MLR reporting year must be the CCN's incurred claims plus the CCN's expenditures for activities that improve health care quality.
  - b. The **denominator** of an CCN's MLR must equal the CCN's capitation payments received from DHH.

## Rebating Capitation Payments if the 85% Medical Loss Ratio Standard is Not Met

### A. General Requirement

## CCN-P REQUEST FOR PROPOSALS

For each MLR reporting year, a CCN must provide a rebate to DHH if the CCN's MLR does not meet or exceed the eight five percentage (85%) requirement.

**B. Amount of Rebate**

For each MLR reporting year, a CCN must rebate to DHH the difference between the total amount of capitation payments received by the CCN from DHH multiplied by the required MLR of 85% and the CCN's actual MLR.

**C. Timing of Rebate**

A CCN must provide any rebate owing to DHH no later than August 1 following the end of the MLR reporting year.

**D. Late Payment Interest**

A CCN that fails to pay any rebate owing to DHH in accordance with paragraph "B" of this section or to take other required action within the time periods set forth in this Part must, in addition to providing the required rebate to DHH, pay DHH interest at the current Federal Reserve Board lending rate or ten percent annually, whichever is higher, on the total amount of the rebate, accruing from August 1.

# Appendix I

## Louisiana Medicaid State Plan Services

## CCN-P REQUEST FOR PROPOSALS

<b>LOUISIANA STATE PLAN SERVICES</b>						
Services	CMS Classification	Children Age 0 through Age 20	Pregnant Women	Adult Ages 21 & Older	Service Limits and/or Prior Authorization	CCN-P Required Services <sup>2</sup>
Audiology Services	Mandatory	√	N/A	N/A	√	√
Early, Periodic Screening, Diagnostic and treatment	Mandatory	√	N/A	N/A	N/A	√
Family Planning	Mandatory	√	N/A	√	√	√
Federally Qualified Health Center	Mandatory	√	N/A	√	√	√
Home Health	Mandatory	√	N/A	√	√	√
Inpatient & Outpatient Hospital Services	Mandatory	√	N/A	√	√	√
Emergency Room Services	Mandatory	√	N/A	√	√	√
Lab & X-Ray	Mandatory	√	N/A	√	√	√
Medical and Surgical Dental Services	Mandatory	√	N/A	N/A	√	√
Nurse Midwife	Mandatory	√	N/A	√	√	√
Nursing Facility	Mandatory	√	N/A	√	√	Not Required
Pediatric and Family Nurse Practitioner	Mandatory	√	N/A	√	√	√
Physician Services	Mandatory	√	N/A	√	√	√
Pregnancy Related Services	Mandatory	√	N/A	√	√	√
Rural Health Clinic	Mandatory	√	N/A	√	√	√
Adult Denture	Optional	N/A	N/A	√	√	Not Required
Adult Immunizations	Optional	N/A	N/A	√	√	√
Ambulatory Surgical Services	Optional	√	N/A	√	√	√
Behavioral / Mental Health (Non-EPSDT)	Optional	N/A	N/A	√	√	Basic Level only
Chiropractic Services	Optional	√	N/A	N/A	√	√
Clinic Services*	Optional	√	N/A	√	√	√
Community Mental Health Services	Optional	√	N/A	√	√	Not Required
Diagnostic Services	Optional	√	N/A	√	√	√
Durable Medical Equipment - Appliances & Supplies	Optional	√	N/A	√	√	√
Emergency Dental Services	Optional	√	N/A	√	√	√
Expanded Dental For Pregnant Women	Optional	N/A	√	N/A	√	Not Required
End Stage Renal Disease Services	Optional	√	N/A	√	√	√
Home Health Extended	Optional	√	N/A	N/A	√	√
Hospice	Optional	√	N/A	√	√	Not Required
Inpatient Psychiatric Services for Children under 21 and Adults over 65	Optional	√	N/A	√	√	Not Required
Medical Transportation	Optional	√	N/A	√	√	√
Optometrist (Non-EPSDT)	Optional	N/A	N/A	√	√	√
Organ Transplants	Optional	√	N/A	√	√	√
Orthodontia	Optional	√	N/A	N/A	√	Not Required
Personal Care Services (Non-EPSDT)	Optional	N/A	N/A	√	√	Not Required
Pharmacy - Cost Share \$.50 - \$3	Optional	√	N/A	√	√	Not Required
Podiatry	Optional	√	N/A	√	√	√
Private Duty Nursing	Optional	√	N/A	√	√	√
Prosthetic & Orthotic Devices	Optional	√	N/A	√	√	√
Rehabilitative Services **	Optional	√	N/A	√	√	√

**Legend:** √ = Covered Service / √ = Service has Limits and/or Requires Prior Authorization / Required N/A = Not Applicable

\*Including non-IEP Medicaid covered services provided in schools, and when such services are not funded through certified public expenditures.

\*\* Excludes specified early steps services.

# **Appendix J**

## **Performance Measures**

## CCN-P REQUEST FOR PROPOSALS

### Louisiana Administrative Performance Measurement Set

Measure	Minimal Performance Standard
% of PCP Practices that provide verified 24/7 phone access with ability to speak with a PCP Practice clinician (MD, DO, NP, PA, RN, LPN) within 30 minutes of member contact.	≥95%
% of regular and expedited service authorization request processed in timeframes in the contract	≥95%
Rejected claims returned to provider with reason code within 15 days of receipt of claims submission	≥99%
% of Call Center calls answered by a live person within 30 seconds	≥90%
Call Center call average speed of answer	30 sec
Call Center call abandonment rate	≤ 5%
% of grievances and request for appeals received by the CCN including grievances received via telephone and resolved within the timeframe of the contract	≥95%
% of clean claims paid for each provider type within 15 business days	≥ 90%
% of clean claims paid for each provider type within 30 calendar days	≥99%
Rejected claims returned to provider with reason code within 15 days of receipt of claims submission	≥99%

**Louisiana CCN Performance Measurement Set**

**Incentive Based Measures**

Access and Availability of Care	Effectiveness of Care		Use of Services
<p><b>\$\$</b> Adults' Access to Preventive/ Ambulatory Health Services</p> <p><b>** HEDIS</b></p>	<p><b>\$\$</b> Comprehensive Diabetes Care HgbA1C</p> <p><b>**HEDIS</b></p>	<p><b>\$\$</b> Chlamydia Screening in Women</p> <p><b>**HEDIS/CHIPRA</b></p>	<p><b>\$\$</b> Well-Child Visits in the Third, Fourth, Fifth and Sixth of Life</p> <p><b>**HEDIS/CHIPRA</b></p>
			<p><b>\$\$</b> Adolescent Well-Care Visits</p> <p><b>**HEDIS/CHIPRA</b></p>

**Level I Measures**

Access and Availability of Care	Effectiveness of Care		Prevention Quality Indicators	Use of Services
<p>Children and Adolescents Access to PCP</p> <p><b>** HEDIS/CHIPRA</b></p>	<p>Childhood Immunization Status</p> <p><b>**HEDIS/CHIPRA</b></p>	<p>Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents</p> <p><b>**HEDIS/CHIPRA</b></p>	<p>Adult Asthma Admission Rate</p> <p><b>**AHRQ</b></p>	<p>Well-Child Visits in the First 15 Months of Life</p> <p><b>**HEDIS/CHIPRA</b></p>
<p>Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care)</p> <p><b>**HEDIS/CHIPRA</b></p>	<p>Immunizations for Adolescents</p> <p><b>**HEDIS/CHIPRA</b></p>	<p>Use of Medication for people with Asthma</p> <p><b>**HEDIS/CHIPRA</b></p>	<p>CHF Admission Rate</p> <p><b>**AHRQ</b></p>	<p>Ambulatory Care (ER Utilization)</p> <p><b>**HEDIS</b></p>
	<p>Cholesterol Management for Patients with cardiovascular conditions</p> <p><b>**HEDIS</b></p>	<p>Comprehensive Diabetes Care</p> <p><b>**HEDIS</b></p>	<p>Uncontrolled Diabetes Admission Rate</p> <p><b>**AHRQ</b></p>	
	<p>Cervical CA Screening</p> <p><b>**HEDIS</b></p>	<p>Breast CA Screening</p> <p><b>**HEDIS/CHIPRA</b></p>	<p>Plan All-Cause Readmissions</p> <p><b>** HEDIS-Adapted for Medicaid</b></p>	
	<p>EPSDT Screening Rate</p> <p><b>**CMS 416</b></p>			

## CCN-P REQUEST FOR PROPOSALS

### Level II Measures

Effectiveness of Care		Use of Services	Satisfaction and Outcomes
Follow-Up Care for Children Prescribed ADHD Medication  <b>**HEDIS/CHIPRA</b>	Cesarean Rate for Low-Risk First Birth Women  <b>**CHIPRA</b>	Emergency Utilization-Avg # of ED visits per member per reporting period <b>**CHIPRA</b>	CAHPS Health Plan Survey 4.0, Adult Version  <b>**HEDIS</b>
Otitis Media Effusion  <b>**CHIPRA</b>	Appropriate Testing for Children With Pharyngitis  <b>**HEDIS/CHIPRA</b>	Annual # of asthma patients (1yr old) with 1 asthma related ER visit  <b>**CHIPRA</b>	CAHPS Health Plan Survey 4.0, Child Version including Children With Chronic Conditions  <b>**HEDIS/CHIPRA</b>
Controlling High Blood Pressure  <b>**HEDIS</b>	% of Pregnant Women who are screened for tobacco usage and secondhand smoke exposure and are offered an appropriate and individualized intervention  <b>** State</b>	Frequency of Ongoing Prenatal care  <b>**HEDIS/CHIPRA</b>	Provider Satisfaction  <b>**State</b>
Pediatric Central-Line Associated Bloodstream Infections  <b>**CHIPRA</b>	Total number of eligible women who receive 17-OH progesterone during pregnancy, and % of preterm births at fewer than 37 weeks and fewer than 32 weeks in those recipients  <b>** State</b>		
Percent of live births weighing less than 2,500 grams  <b>**CHIPRA</b>			

# **Appendix K**

## **WIC Referral Form**

## CCN-P REQUEST FOR PROPOSALS

### SAMPLE WIC REFERRAL FORM

PL103-448, §204(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: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

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

- Pregnant woman
- Woman who is breast-feeding her infant(s) up to one year postpartum
- Woman who is not 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.

I, the undersigned, give permission for my provider to give the WIC Program any required 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:

## **Appendix L**

# **Hysterectomy Consent Form**

CCN-P REQUEST FOR PROPOSALS

BHSF Form 96A  
Revised 05/06

Medicaid Program  
Acknowledgment of Receipt of Hysterectomy Information

Recipient Name: \_\_\_\_\_

MEDS Person No.: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Provider No.: \_\_\_\_\_

Payment by Louisiana’s **Medicaid Program cannot** be authorized for **any** hysterectomy performed **solely** for the purpose of rendering an individual permanently incapable of reproducing or where, if there is more than one purpose for the procedure, the hysterectomy would not be performed except for the purpose of rendering the individual permanently incapable of reproducing.

Medicaid payment for a medically indicated hysterectomy can be authorized **only** if:

- (1) the individual and her representative\*, if any, are informed orally and in writing that the hysterectomy will render her permanently incapable of reproducing; and,
- (2) the individual and her representative\* if any, have signed a written acknowledgment of receipt of that information. The written acknowledgment must be signed and dated prior to the operation and must be attached to the claim form when it is submitted for payment.

\* A representative is that person who has the legal authority to act for an individual. For purposes of this acknowledgment, a representative shall be defined as either the curator of an interdicted woman or the tutor or parent of an unmarried minor. A minor emancipated by marriage is deemed capable of acting for herself in the matter.



I hereby acknowledge that I have been informed orally and in writing that a hysterectomy (surgical removal of the uterus) will render a woman permanently incapable of bearing children.

\_\_\_\_\_  
Signature of Recipient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Representative, if any

\_\_\_\_\_  
Date

# **Appendix M**

## **Sterilization Consent Form**

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from [Name] . When I first asked [Doctor or Clinic]

for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a [Specify Type of Operation] . The discomforts, risks

and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: [Date]

I, [Name], hereby consent of my own free will to be sterilized by [Doctor or Clinic]

by a method called [Specify Type of Operation] . My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

[Signature] [Date]

You are requested to supply the following information, but it is not required: (Ethnicity and Race Designation) (please check)

Ethnicity: Race (mark one or more):

- Hispanic or Latino
American Indian or Alaska Native
Not Hispanic or Latino
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in [Language]

language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

[Interpreter's Signature] [Date]

STATEMENT OF PERSON OBTAINING CONSENT

Before [Name of Individual] signed the

consent form, I explained to him/her the nature of sterilization operation [Specify Type of Operation], the fact that it is

intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

[Signature of Person Obtaining Consent] [Date]

[Facility]

[Address]

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

[Name of Individual] on [Date of Sterilization]

I explained to him/her the nature of the sterilization operation [Specify Type of Operation], the fact that it is

intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraph: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery
Individual's expected date of delivery: [Date]
Emergency abdominal surgery (describe circumstances): [Description]

[Physician's Signature] [Date]

## CCN-P REQUEST FOR PROPOSALS

### **PAPERWORK REDUCTION ACT STATEMENT**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0937-0166. The time required to complete this information collection is estimated to average 1 hour 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 537-H, Washington D.C. 20201, Attention: PRA Reports Clearance Officer

# **Appendix N**

## **Abortion Consent Form**

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**Instructions for Completing the  
Certification of Informed Consent - Abortion**

Acts 2007, No. 281 Section 1 amends and reenacts R.S. 40:1299.35.6 to provide for:

*...Informed consent of a woman upon whom an abortion is to be performed or induced; to require that certain information be provided to such a woman, except in case of medical emergency; to require certain certification; to require publication and provision of certain information and materials; to require certain information in cases of medical emergency; to require certain reports; to provide for civil and criminal penalties and sanctions; to provide for severability, construction, and right of intervention; and to provide for related matters.*

---

The **CERTIFICATION OF INFORMED CONSENT - ABORTION** form is an important legal document. Properly prepared, it is proof that the physician or qualified agent of the physician complied with the statutory requirement that the pregnant woman received complete information about her alternatives and voluntarily consented to an abortion at least twenty-four hours prior to having the abortion. Complete the form in accordance with the following instructions:

- All entries must be in ink. Type, print or stamp all entries other than the pregnant woman's confirmation initials.
- In the upper left, enter the name and the address of the facility. A stamped name and address is acceptable.
- In Sections I and II, type, print or stamp the name of the individual who presented the information and indicate whether that person is the physician who will perform the abortion, a referring physician, or a qualified agent of the physician (if applicable) by entering check marks in the appropriate spaces. Have the pregnant woman read the sections and initial in the space provided to acknowledge receipt of information.
- In Section III, type, print or stamp the name of the individual who presented the information and indicate whether that person is the physician who will perform the abortion, a referring physician, or a qualified agent of the physician by entering a check mark in the appropriate space. Have the pregnant woman read the section and initial in the space provided to acknowledge receipt of the printed materials, and complete the date/time that the printed materials were received.

The **CERTIFICATION OF INFORMED CONSENT - ABORTION** form is a snapset composed of an instruction sheet, and an original and two copies of the consent form. Submit the original to:

Abortion Registration Clerk  
Vital Records Registry  
P. O. Box 60630  
New Orleans, LA 70160  
(504) 219-4500

If information or materials are provided by a referring physician, submit the original to the above-referenced. Give the first and second copies to the patient, with verbal instructions to bring one copy to the physician who is to perform the abortion. It is recommended that the referring physician retain a photocopy of the consent form and make it a part of the patient's medical record.

The physician accepting referral and who performs the abortion is responsible for reporting the abortion on standard form PHS 16-ab (Report of Induced Termination of Pregnancy) within 15 days of the abortion. Attach the Certification of Informed Consent-Abortion received by referral to the PHS 16-ab and submit the documents within the prescribed filing time to the mailing address listed above.

If information or materials are provided by the physician who will perform the abortion, retain the first copy of the consent form in the patient's medical record and give the second copy to the patient. Attach the Certification of Informed Consent-Abortion to the PHS 16-ab and submit the documents within the prescribed filing time to the mailing address listed above.

To be completed by the Provider: **CCN-P**  
Name, address of facility:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## REQUEST FOR PROPOSALS

### DEPARTMENT OF HEALTH AND HOSPITALS OFFICE OF PUBLIC HEALTH CERTIFICATION OF INFORMED CONSENT-ABORTION

Please initial each section to indicate the information was provided to you. This information should be provided to you individually, and in a private room, to protect your privacy and to maintain the confidentiality of your decision, and also to ensure that the information given focuses on your individual circumstances, and that you are afforded an adequate opportunity to ask questions.

**SECTION I.** The following information was presented to me, orally and in person, at least 24 hours prior to the abortion by \_\_\_\_\_, who is (check one): \_\_\_ the physician who is to perform the abortion; \_\_\_ a referring physician.

- The name of the physician who will perform the abortion.
- A description of the proposed abortion method, medical risks, and alternatives to abortion.
- The probable gestational age of the unborn child at the time the abortion is to be performed.
- If the unborn child is viable or has reached the gestational age of twenty-four (24) weeks and the abortion may be otherwise lawfully performed under existing law, that:
  1. The unborn child may be able to survive outside the womb.
  2. The woman has the right to request the physician to use the method of abortion that is most likely to preserve the life of the unborn child.
  3. If the unborn child is born alive, that attending physicians have the legal obligation to take all reasonable steps necessary to maintain the life and health of the child.
- The probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed.
- The medical risks associated with carrying the child to term.
- Any need for anti-RH immune globulin therapy, if RH negative; the likely consequences of refusing such therapy; and a good faith estimate of the cost of the therapy.
- The availability of anesthesia or analgesics to alleviate or eliminate organic pain to the unborn child that could be caused by the method of abortion to be employed.
- The option of reviewing and receiving an explanation of an obstetric ultrasound image of the unborn child. This option shall not require me to view or receive an explanation of the obstetric ultrasound images. I shall not be penalized, and my physician shall not be penalized, if I choose not to view or receive an explanation of the obstetric ultrasound images.

Initials: \_\_\_\_\_

**SECTION II.** The following information was presented to me, orally and in person, at least 24 hours prior to the abortion by \_\_\_\_\_, who is (check one): the physician who is to perform the abortion; \_\_\_ a referring physician; \_\_\_ a qualified agent of the physician (Psychologist, Licensed Social Worker, Licensed Professional Counselor, Registered Nurse, Physician).

- That medical assistance benefits may be available for prenatal care, childbirth, and neonatal care. More detailed information on the availability of such assistance is contained in the directory.
- That the pamphlet describes the unborn child and contains a directory of agencies that offer abortion alternative.
- That the father of the unborn child is liable to assist in the support of the child, even if he has offered to pay for the abortion. (In the case of rape this information may be omitted.)
- That I am free to withhold or withdraw my consent to the abortion at any time before or during the abortion without affecting my right to future care or treatment and without the loss of any state or federally funded benefits to which I might otherwise be entitled.

Initials: \_\_\_\_\_

**SECTION III.** The following printed materials were provided to me, at least 24 hours prior to the abortion, by \_\_\_\_\_, who is (check one): \_\_\_\_\_ the physician who is to perform the abortion; \_\_\_\_\_ a referring physician; \_\_\_\_\_ a qualified agent of the physician (Psychologist, licensed Social Worker, Licensed Professional Counselor, Registered Nurse, Physician).

- The pamphlet titled "Abortion: Making A Decision" and the directory of agencies that offer abortion alternatives. [If you are unable to read, they shall be read to you.]  
The pamphlet and directory were provided to me on:

Date: \_\_\_\_\_ Time: \_\_\_\_\_ A.M. or P.M. (Circle one)

Initials: \_\_\_\_\_

# **Appendix O**

## **CCN Subcontract Requirements**



Louisiana Coordinated Care Network Program

CCN-P Provider Subcontract Requirements	
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 <b>shall not propose</b> to subcontractors reimbursement rates that are less than the published Medicaid fee-for-service rate.	<input type="checkbox"/>
Contain language that the subcontractor shall adhere to all requirements set forth for CCN subcontractors in the DHH/CCN Contract and Department-issued guides; 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.	<input type="checkbox"/>
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.	<input type="checkbox"/>
Specify the effective dates of the subcontract agreement.	<input type="checkbox"/>
Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	<input type="checkbox"/>
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 CCN bulletins, if mutually agreed to in terms of the subcontract and with prior notice to DHH.	<input type="checkbox"/>
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.	<input type="checkbox"/>

## CCN-P Provider Subcontract Requirements

<p>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.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>
<p>Identify the population covered by the subcontract.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>
<p>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).</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>
<p>Specify the amount, duration and scope of core benefits and services as specified in the Louisiana Medicaid State Plan that are provided by the e subcontractor, including all specific requirements outlined in the Contract between DHH and the CCN.</p>	<input type="checkbox"/>
<p>Provide that emergency services be rendered without the requirement of prior authorization of any kind.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>

## CCN-P Provider Subcontract Requirements

<p>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.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>
<p>Include medical record requirements as specified in the contract between DHH and the CCN.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>

## CCN-P Provider Subcontract Requirements

<p>Require the subcontractor comply and submit to the CCN disclosure of information in accordance with the requirement specified in 42 CFR §455, Subpart B.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>
<p>Require that the subcontractor comply with any corrective action plan initiated by the CCN and/or required by DHH.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>
<p>Provide for submission of all reports and clinical information required by the CCN for reporting purposes such as HEDIS, AHRQ, and EPSDT.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>
<p>Provide the name and address of the official payee to whom payment shall be made.</p>	<input type="checkbox"/>
<p>Make full disclosure of the method and amount of compensation or other consideration to be received from the CCN.</p>	<input type="checkbox"/>
<p>Provide for prompt submission of complete and accurate claims information needed to make payment.</p>	<input type="checkbox"/>

## CCN-P Provider Subcontract Requirements

<p>Provide that the CCN shall pay ninety percent (90%) of all clean claims of each provider type, within fifteen (15) business days of the date receipt. The CCN shall pay ninety-nine (99%) of all clean claims of each provider type, within thirty (30) calendar days of the date of receipt. The date of receipt is the date the CCN receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment. The CCN and its subcontractors may, by mutual agreement, establish an alternative payment schedule. Any alternative schedule must be stipulated in the subcontract.</p>	<input type="checkbox"/>
<p>Provide that subcontractors must submit all clean claims for payment no later than twelve (12) months from the date of service.</p>	<input type="checkbox"/>
<p>Specify that the subcontractor shall accept the final payment made by the CCN as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from DHH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>
<p>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</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>

## CCN-P Provider Subcontract Requirements

<p>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 subcontract and with prior notice to DHH.</p>	<input type="checkbox"/>
<p>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 DHH/CCN 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 its subcontractor's activities undertaken pursuant to the subcontract. The provision of such records shall be at no expense to DHH.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>
<p>Include a conflict of interest clause as stated in the Contract between DHH and the CCN.</p>	<input type="checkbox"/>
<p>Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as described in the Contract between DHH and the CCN and <i>Quality Companion Guide</i>. The QAPI and UM requirements shall be included as part of the subcontract between the CCN and the subcontractor.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>
<p>Contain no provision which provides incentives, monetary or otherwise, for the withholding of medically necessary care.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>
<p>Specify that hospital subcontracts require that the hospital notify the CCN and DHH of the birth of a newborn when the mother is a member of the CCN and require that the hospital complete the web-based DHH Request for Medicaid ID Number, including indicating that the mother is a member of the CCN, and submitting the form electronically to DHH.</p>	<input type="checkbox"/>

## CCN-P Provider Subcontract Requirements

<p>For any subcontract with an FQHC/RHC, the subcontract shall specify that the CCN shall reimburse the FQHC/RHC the PPS rate in effect on the date of service for each encounter.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>
<p>Contain no provision which restricts a subcontractor from subcontracting with another CCN or other managed care entity.</p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>

## CCN-P Provider Subcontract Requirements

<p>When the CCN has entered into alternative reimbursement arrangements with subcontractors (with prior approval by the Department), require submission of all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims by the CCN. <i>NOTE: CCN shall not enter into alternative reimbursement arrangements with FQHCs or RHCs.</i></p>	<input type="checkbox"/>
<p>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.</p>	<input type="checkbox"/>
<p>State that in accordance with 42 CFR §438.106(c) and 1932(b)(6) subcontractors shall not bill members any amount greater than would be owed if the CCN provided the services directly.</p>	<input type="checkbox"/>
<p>Provide that subcontractors must submit all claims for payment no later than twelve (12) months from the date of service. EPSDT screening claims should be submitted within sixty (60) days from date of service to accommodate for frequency of screening services and for EPSDT reporting requirements. EPSDT screening claims must also include information related to immunizations, referrals and health status as published in the EPSDT Services Rule (<i>Louisiana Register, Vol 30, No. 8</i>).</p>	<input type="checkbox"/>
<p>Provide that subcontractors, as applicable, register all births through LEERS (Louisiana Electronic Event Registration System) administered by DHH/Vital Records Registry.</p>	<input type="checkbox"/>
<p>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 <b>total number</b> of Medicaid members for the CCN Program will not exceed 2,500 lives.</p>	<input type="checkbox"/>

# **Appendix P**

## **CCN Data Use Agreement**

## CCN-P REQUEST FOR PROPOSALS

### **Data Use Agreement Between Louisiana Department of Health and Hospitals And Coordinated Care Network (CCN) Proposer**

This Data Use Agreement for a Limited Data Set is entered into by and between the following parties and shall become effective immediately upon being signed by both parties:

**Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF)**, hereinafter referred to as “DHH” or “Data Owner”;  
and \_\_\_\_\_,  
potential proposer, hereinafter referred to as “Data User.”

#### **Purpose of Agreement:**

DHH, through its Bureau of Health Services Financing (BHSF), administers the Louisiana Medicaid program. BHSF, as the Data Owner, has issued a Request for Proposals (RFP) for the operation of its new Coordinated Care Network (CCN) program, and the Data User will submit a proposal to DHH in response to that RFP. The Data User will analyze all Medicaid claims data solely at its own expense and at no cost to DHH. DHH will provide the Data User with the specific Limited Data Set information described below.

#### **Obligations of Data Owner:**

DHH, as the Data Owner, agrees to provide the following described information to the Data User. The Limited Data Set below, as defined in the HIPAA Privacy Rule, to the Data User constitutes:

Twenty-four (24) months of claims and eligibility data to include July 1, 2008 – June 30, 2010 with the inclusion of select denied claims for service limitations and the exclusion of pending claims. Protected Health Information (PHI) will be excluded. The following files will be included:

- a. Professional and institutional claims (Claims\_FY09\_CCN.sas7bdat and Claims\_FY10\_CCN.sas7bdat)
- b. Pharmacy claims (Rx\_FY09\_CCN.sas7bdat and Rx\_FY10\_CCN.sas7bdat)
- c. Eligibility data (Eligibility\_CCN\_FY09.sas7bdat and Eligibility\_CCN\_FY10.sas7bdat)
- d. Deliveries data (Deliveries\_CCN.sas7bdat)
- e. Outliers data (Outliers\_CCN.sas7bdat)



LA

Contents\_CCN\_0406:

MVA's point of contact regarding this data set will be Ruth Kennedy of the Medicaid CCN Director ( [Ruth.Kennedy@la.gov](mailto:Ruth.Kennedy@la.gov) ). All data will be used for business nature only.

**Obligations of Data User:**

The Data User shall limit access to Limited Data Set information strictly to those individuals or classes of individuals who shall have access in order to perform their duties in connection with the below described purposes related to the Louisiana Coordinated Care Network RFP, which is part of the health care operations of Louisiana Medicaid.

- a. *Uses and Disclosures as Requested in this Agreement.* With sole regard to this RFP the Data User shall use and disclose the Limited Data Set information provided by the Data Owner only for the following purposes directly related to development of proposals for this RFP:

Analysis for preparation of CCN proposal

- b. *Nondisclosure except as Provided in this Agreement.* The Data User shall not use or further disclose the Limited Data Set information except as specified in this Agreement.
- c. *Follow-Back.* The Data User shall not contact the subjects of the information, the subjects' next-of-kin, the subjects' physicians or other providers, or any other relative or interested party.
- d. *Safeguards.* The Data User agrees to take appropriate administrative, technical and physical safeguards to protect the Limited Data Set information from any unauthorized use or disclosure not provided for in this Agreement. The Data Owner shall ensure that no identifying information is transmitted through unsecured telecommunications, including unsecured Internet connections.
- e. *Reporting.* Within 48 hours of the Data User's discovery, the Data User shall report to the Data Owner any use or disclosure of the Limited Data Set information that violates either this Agreement or applicable state or federal laws or regulations.
- f. *Public Release.* No Limited Data Set information or analysis of information shall be publicly released.
- g. *Breach of Agreement by Data User.* In the event that the Data User breaches this Agreement, the Data Owner, at its sole discretion, may: (1) terminate this Agreement upon written notice to the Data User, or (2) request that the Data User, to the satisfaction of the Data Owner, take appropriate steps to cure such breach. If the Data User fails to cure such breach to the Data Owner's satisfaction or in the time prescribed by the Data Owner, the Data Owner may terminate this Agreement and/or disqualify the Data User as a CCN proposer upon written notice to the Data User.
- h. *Termination of Agreement and Destruction of Records.* This Agreement shall terminate upon any of the following events, whichever occurs first: (1) termination by the Data Owner as provided in paragraph (g); (2) termination by either party for any reason upon giving five (5) days' written notice to the other party; (3) the completion of Data User's analysis and the submission of its proposal to the Data Owner; or (4) the date of deadline for submission of proposal. Immediately upon termination of this Agreement, the Data User shall destroy all Limited Data Set information provided to it by the Data Owner.

CCN-P REQUEST FOR PROPOSALS

- i. *Minimum Necessary.* The Data User attests that the Limited Data Set information requested represents the minimum information necessary for the Data User to perform the tasks called for in this Agreement, and that only the minimum necessary individuals shall have access to the information in order to perform such tasks.
- j. *Data Ownership.* DHH is the Data Owner. The Data User does not obtain any right, title or interest in any of the data furnished by DHH.

By signing this Agreement, the authorized representatives of DHH and the Data User agree to all of its provisions.

**IN WITNESS WHEREOF**, the parties hereto have duly executed this Agreement as of the date(s) written below.

Louisiana Department of Health and Hospitals (DHH), Bureau of Health Services Financing (BHSF)

By: \_\_\_\_\_ Date \_\_\_\_\_  
Don Gregory, Medicaid Director, DHH/BHSF  
(225) 342-3891  
Don.Gregory@LA.GOV

\_\_\_\_\_  
Printed Name of Data User (Proposer) Company

By: \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Data User (Proposer) Representative

\_\_\_\_\_  
Printed Name of Data User (Proposer) Representative

## **Appendix Q**

# **Requirements for CCN-P Physician Incentive Plans**

Appendix Q

**Louisiana Medicaid Coordinated Care Network Program  
Requirements for CCN-P Physician Incentive Plans**

The Physician Incentive Plan (herein referred to as Plan) rules apply to Medicaid prepaid organizations subject to section 1903(m) of the Social Security Act, *i.e.*, requirements for federal financial participation in contract costs, including both federally qualified MCOs and State Plan defined MCOs.

The CCN may operate a Plan only if - (1) no specific payment is made directly or indirectly under the physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee; and (2) the stop-loss protection, enrollee survey, and disclosure requirements in this appendix are met.

The CCN must maintain adequate information specified in the Plan regulations and make available to DHH, if requested, in order that DHH may adequately monitor the CCN's Plan if applicable. The disclosure must contain the following information in detail sufficient to enable DHH to determine whether the incentive plan complies with the Plan requirements:

1. Whether services not furnished by the physician group are covered by the incentive plan. If only the services furnished by the physician or physician group are covered by the incentive plan, disclosure of other aspects of the plan need not be made.
2. The type of incentive arrangement; for example, withhold, bonus, capitation.
3. If the incentive plan involves a withhold or bonus, the percent of the withhold or bonus.
4. Proof that the physician or physician group has adequate stop-loss protection, including the amount and type of stop-loss protection.
5. The panel size and, if patients are pooled, the approved method used.
6. In the case of capitated physicians or physician groups, capitation payments paid to primary care physicians for the most recent calendar year broken down by percent for primary care services, referral services to specialists, and hospital and other types of provider (for example home health agency) services.
7. In the case of those prepaid plans that are required to conduct beneficiary surveys, the survey results (which must be provided in a timely manner to Medicaid recipients upon request)

The disclosure requirements numbers 1 through 5 must be provided prior to Contract approval and upon the effective date of its renewal. Disclosure requirement number 6 must be provided for the previous calendar year by April 1 of each year.

The CCN must disclose this information to DHH when requested. The CCN must provide the capitation data required no later than three (3) months after the end of the calendar year. The CCN will provide to the beneficiary upon request whether the prepaid plan uses a physician incentive plan that affects the use of referral services, the type of incentive arrangement,

## CCN-P REQUEST FOR PROPOSALS

whether stop-loss protection is provided, and the survey results of any enrollee/disenrollee surveys conducted.

### Disclosure Requirements Related to Subcontracting Arrangements

A CCN that contracts with a physician group that places the individual physician members at substantial financial risk for services they do not furnish must do the following:

- Disclose to DHH, upon request, any incentive plan between the physician group and its individual physicians that bases compensation to the physician on the use or cost of services furnished to Medicaid recipients. The disclosure must include the required information and be made at the times specified.
- Provide adequate stop-loss protection to the individual physicians.
- Conduct enrollee surveys.

A CCN that contracts with an intermediate entity (e.g., an individual practice association, or physician hospital organization) and which bases compensation to its contracting physicians or physician groups on the use or cost of referral services furnished to Medicaid/CHIP recipients must comply with requirements above.

### Recipient Survey

42 CFR 417.479(g)(1) requires that organizations that operate incentive plans that place physicians or physician groups at Substantial Financial Risk (SFR) must conduct surveys of enrollees. Surveys must include either all current Medicaid/CHIP members in the CCN's plan and those that have disenrolled other than because of loss of eligibility or relocation, or choose to conduct a valid statistical sample.

According to 42 CFR 417.479(g)(iv), enrollee surveys must be conducted no later than one year after the effective date of the Contract and at least annually thereafter. As long as physicians or physician groups are placed at SFR for referral services, surveys must be conducted **annually**. The survey must address enrollees/disenrollees satisfaction with the quality of services, and their degree of access to the services. DHH has the authority to utilize the Medicaid version of CAHPS to meet the survey requirement. CCNs, upon completion of approved survey tool, will be expected to compile, analyze and summarize survey data within 120 days and submit the results to the DHH.

**Note:** If disenrollment information is obtained at the time of disenrollment from all recipients, or a survey instrument is administered to a sample of disenrollees, that method will meet the disenrollee survey requirements for the Contract year.

### Sanctions

Section 1903(m) of the Act specifies requirements that must be met for states to receive FFP for contracts with CCNs, (42 CFR 434.70(a)(2002, as amended) and sets the conditions for Federal Financial Participation (FFP). Federal funds will be available to Medicaid for payments to CCNs only for the periods that the CCNs comply with the Plan requirements in 42 CFR 417.479(d)-(g), (h)(1), (h)(3), and 417.479(I) requirements related to subcontractors. These regulations cover: 1) the prohibition of physician payments as an inducement to reduce or limit

## CCN-P REQUEST FOR PROPOSALS

covered medically necessary services furnished to an individual enrollee, 2) proper computation of substantial financial risk, 3) physician stop-loss protection, 4) enrollee survey requirements, and 5) disclosure requirements.

42 CFR 434.70(b) provides that CMS may withhold FFP for any period during which the State fails to meet the State plan requirements of this part.

### *Intermediate Sanctions and/or Civil Money Penalties*

42 CFR 438.700(a) states that intermediate sanctions (42 CFR 438.702, types of intermediate sanctions) may be imposed on a CCN with a risk comprehensive contract which fails to comply with any of the requirements of 417.479(d) - (g), or fails to submit to DHH its physician incentive plans as required or requested in 42 CFR 422.208 and 422.210.

In accordance with 42 CFR 1003.103(f)(1)(vi), the OIG may impose a Civil Monetary Penalty of up to \$25,000 for each determination by CMS that a contracting organization has failed to comply with 417.479(d) - (g) and 434.70. Civil Monetary Penalties may be imposed on the organization in addition to, or in place of the imposed sanctions.

### **Definitions for Physician Incentive Plan Requirements**

**Physicians Incentive Plan** - Any compensation arrangement between a Contractor and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicaid recipients enrolled in the CCN.

**Physician Group** - A partnership, association, corporation, individual practice association (IPA), or other group that distributes income from the practice among members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

**Intermediate Entity** - Entities which contract between a CCN or one of its contractors and a physician or physician group. An Individual Practice Association (IPA) is considered an intermediate entity if it contracts with one or more physician groups in addition to contracting with individual physicians.

**Substantial Financial Risk** - An incentive arrangement based on referral services that place the physician or physician group at risk for amounts beyond the risk threshold. The risk threshold is 25 percent.

**Bonus** - A payment that a physician or entity receives beyond any salary, fee-for service payment, capitation, or returned withhold. Quality bonuses and other compensation that are not based on referral levels (such as bonuses based solely on care, patient satisfaction or physician participation on a committee) are not considered in the calculation of substantial financial risk, but may be revisited at a later date.

**Capitation** - A set dollar payment per patient per unit of time (usually per month) that is paid to cover a specified set of services and administrative costs without regard to the actual number of services provided. The services covered may include the physician's own services, referral services, or all medical services.

## CCN-P REQUEST FOR PROPOSALS

**Payments** - The amount a CCN pays physicians or physician group for services they furnish directly, plus amounts paid for administration and amounts paid (in whole or in part) based on use and costs of referral services (such as withhold amounts, bonuses based on referral levels, and any other compensation to the physician or physician group to influence the use of referral services). Bonuses and other compensation that are not based on referral levels (such as bonuses based solely on quality of care furnished, patient satisfaction, and participation on committees) are not considered payments for purposes of this subpart.

**Referral Services** - Any specialty, inpatient, outpatient, or laboratory services that a physician or physician group orders or arranges, but does not furnish.

**Risk Threshold** - The maximum risk, if the risk is based on referral services, to which a physician or physician group may be exposed under a physician incentive plan without being at substantial financial risk. The risk threshold is 25 percent.

**Withhold** - A percentage of payments or set dollar amount that an organization deducts for a physician's service fee, capitation, or salary payment, and that may or may not be returned to the physician, depending on the specific predetermined factors.

# **Appendix R**

## **Provider's Bill of Rights**

## CCN-P REQUEST FOR PROPOSALS

### **PROVIDER'S BILL OF RIGHTS**

Each CCN network provider who contracts with a CCN 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 State Fair Hearing procedures.
- To have access to the CCN's policies and procedures covering the authorization of services.
- To be notified of 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.
- To challenge, at the request of the Medicaid/CHIP member on their behalf, the denial of coverage of, or payment for, medical assistance.
- The CCN's 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.

## **Appendix S**

# **Request for Newborns Manual**

**Department of Health and Hospitals Newborn  
Eligibility System  
User Manual**

**Revised: August 2008**

**Table of Contents**

DHH Newborn Eligibility System ..... 2

    Login Process..... 2

    Start a new form ..... 2

        No to the First Question, Yes to the Second Question ..... 4

Newborn Eligibility ID Assignment Request form ..... 4

    Phone/Fax Fields ..... 4

    Date Fields..... 5

    Physician and Pediatrician Information Areas ..... 5

    Doctor Auto-Fill..... 6

    Additional Providers Information Areas ..... 7

    Complete Screen ..... 8

Third Party Liability (TPL) Notification of Newborn Children Form ..... 10

    TPL Notification Input Screen ..... 10

        Hospital Information ..... 10

        Mother’s Information ..... 10

        Father’s Information ..... 11

        Newborn Information ..... 12

        Insurance Plan Information..... 12

        Complete Screen ..... 14

    Resume TPL Notification ..... 15

    Your History ..... 15

Questions or Comments ..... 16

## DHH Newborn Eligibility System

### *Login Process*

The login process is very simple. Enter a valid ID and password to gain access to the DHH Newborn Eligibility System. The Login ID is entered into the Login ID field provided, and then the password. The password will appear as a series of hidden characters to prevent unauthorized persons from viewing the actual password.

Once both Login ID and password are entered, either click the login button or press enter. If any information is incorrect or invalid, you will be returned to the login screen and will be prompted to correct it before you may continue.

Department of Health and Hospitals  
Medicaid Program  
Request for Newborn Medicaid ID Number

Blank Newborn ID  
Blank TPL

Login ID:

Password:

Login

Passwords are case sensitive. For example, "mypassword" and "MYPASSWORD" are considered two different passwords.

It is recommended that you use [Microsoft Internet Explorer 5.0](#) or above, or [Netscape 6.0](#) and above, or [Mozilla](#)

### *Start a new form*

After completing the login process the user is prompted to answer two questions about the mothers Medicaid eligibility and the status of insurance for the mother or father. These two questions must be answered based on the applicant's current information. The user will be directed to complete

the Newborn Eligibility ID Assignment Request and/or a Third Party Liability (TPL) Notification of Newborn Children based on information provided.

## Login Questions

Does the mother have Medicaid?

Does the mother or father have access to employer sponsored health insurance?

Department of Health and Hospitals  
Medicaid Program  
Request for Newborn Medicaid ID Number

Newborn Eligibility Unit

Log Out  
Start New Form  
Resume TPL Notification  
Your History  
Blank Newborn ID  
Blank TPL  
User Manual

Start New Form

Does the mother have Medicaid?  Yes  No

Does the mother or father have access to employer sponsored health insurance?  Yes  No

Submit

## Yes to Both Questions

When the answer is yes to both of these questions the user will be prompted to first complete a Newborn Eligibility ID Assignment Request form. Please refer to section 2.3 Newborn Eligibility ID Assignment Request form for directions on completion.

After successfully submitting a completed Newborn Eligibility ID Assignment Request form the user will be prompted to continue and complete a Third Party Liability (TPL) Notification of Newborn Children form. The TPL Notification of Newborn Children form is identified as a TPL form. The user may choose to fill out the TPL Notification of Newborn Children form at this time or resume later if additional information is needed from the client or to notify someone in your hospital to finalize completion of this process.

### No to the First Question, Yes to the Second Question

When the answer to the first login question is no but the answer to the second login question is yes the user will be prompted to complete a TPL Notification of Newborn Children form. Please see section 2.4 for directions to complete the TPL Notification of Newborn Children form.

### Newborn Eligibility ID Assignment Request form

The Newborn Eligibility ID Assignment Request form provides a web interface for hospitals to quickly submit information to DHH. Each field is required to be answered before the form may be submitted.

#### *Phone/Fax Fields*

All fields which require phone numbers are setup to allow for quick entry. When entering a phone number, the system will automatically add in the appropriate formatting for the phone number. Each number should be in the format of 999 999-9999. the system will automatically jump from the area code to the main number once three characters are entered into the field.

**Date Fields**

All fields which require dates are setup to allow for quick entry. When typing a date, the system will automatically add in the appropriate formatting for the date. Each date should be in the format of MM/DD/YYYY.

Department of Health and Hospitals  
 Medicaid Program  
 Request for Newborn Medicaid ID Number

Newborn Eligibility Unit

Log Out  
 Start New Form  
 Resume TPL Notification  
 Your History  
 Blank Newborn ID  
 Blank TPL  
 User Manual

\* Fields in red indicate that they are required.

**Mother Information**

Mother's Name (First, MI, Last) [ ] [ ] [ ]  
 Mother's Medicaid No. [ ]  
 Mother's DOB [ ]  
 Mother's SSN [ ]  
 Date of Admission [ ]  
 Mailing Address [ ]  
 [ ]  
 [ ]  
 City [ ]  
 State LA [ ]  
 Zip Code [ ]  
 Parish of Residence -- SELECT PARISH -- [ ]  
 Telephone [ ] [ ]

Upon release from the hospital, will the newborn live with the mother?  
 YES  
 NO

**Child / Birth Information**

Special Notes  
 Twin A  Twin B  NICU  Adoption -- Date of Mother's Discharge: [ ]  
 Expired -- Date of Death: [ ] Other: [ ]  
 Corrected (What is being corrected?) [ ]

**Physician and Pediatrician Information Areas**

Because the information in the Physician and Pediatrician fields may often be the same as the hospital's information, you may click the Use Hospital button above each area to quickly fill in the fields with the information already available in the system.

Similarly, if the information for either is the same as the other (Pediatrician same as Pediatrician and vice versa), you may click the Copy button above each area to copy the information already entered on the web page.

## CCN-P REQUEST FOR PROPOSALS

NO

Physician Information		Use Hospital	Copy Ped.
Find Doctor:	<input type="text" value="-- SELECT DOCTOR --"/>		
Name	<input type="text"/>		
Phone	<input type="text"/>		
Fax	<input type="text"/>		
Address	<input type="text"/>		
	<input type="text"/>		
City	<input type="text"/>		
State	<input type="text" value="LA"/>		
Zip	<input type="text"/>		

Pediatrician Information		Use Hospital	Copy Phys.
Find Doctor:	<input type="text" value="-- SELECT DOCTOR --"/>		
Name	<input type="text"/>		
Phone	<input type="text"/>		
Fax	<input type="text"/>		
Address	<input type="text"/>		
	<input type="text"/>		
City	<input type="text"/>		
State	<input type="text" value="LA"/>		
Zip	<input type="text"/>		

**Additional Providers**

Automatic Refresh in 13 minutes and 0 seconds Local intranet

### ***Doctor Auto-Fill***

The system may have some of the doctors you commonly use predefined in the system. If there are any, they will be listed in the Find Doctor area for each associated doctor. Simply select the name of the doctor you wish to use; there will be small pause while the system retrieves the corresponding information.

Once the information is populated on your form, you may change it if necessary to reflect the specific needs for this filing. Any changes you make will only be associated for the current filing.

## CCN-P REQUEST FOR PROPOSALS

The screenshot shows a web form with the following sections and fields:

- Top Section:** Fields for Name, Fax, Address, City, State (LA), and Zip.
- Pediatrician Information:** A section header with a blue background. To its right are two buttons: "Use Hospital" and "Copy Phys.". Below the header is a "Find Doctor:" dropdown menu with a red arrow pointing to it. The dropdown menu is open, showing options: "-- SELECT DOCTOR --", "-- SELECT DOCTOR --", "Doctor, Jack", "Doctor, Jane" (highlighted), "Doctor, Jill", and "Doctor, John". Below the dropdown are fields for Name, Phone, Fax, Address, City, State (LA), and Zip.
- Additional Providers:** A section header with a blue background. Below it is a checkbox labeled "Include Additional Providers".
- Facility Representative Information:** A section header with a blue background. Below it are fields for Representative Name and Phone Number.
- Bottom:** A "Submit" button and a status bar showing "Automatic Refresh in 19 minutes and 26 seconds" and "Local intranet".

### ***Additional Providers Information Areas***

Because the information in the Additional Providers fields may not be used for every filing, the fields will be hidden by default. To enter information in these fields, click the Include Additional Providers check box and the fields will be displayed.

If the check box is not checked, then the fields will be hidden and any data already entered into them will not be submitted with the filing. The check box must be checked for any Additional Provider data to be submitted with the filing. Once data is entered into any field for an additional provider, the rest of the fields for that provider will become mandatory.

## CCN-P REQUEST FOR PROPOSALS

The screenshot shows a web form with the following fields and sections:

- State: LA (dropdown)
- Zip: [text input]
- Additional Providers** (Section Header, highlighted with a red arrow)
- Include Additional Providers
- Find Doctor: -- SELECT DOCTOR -- (dropdown)
- Name: [text input]
- Phone: [text input]
- Fax: [text input]
- Address: [text input]
- City: [text input]
- State: LA (dropdown)
- Zip: [text input]
- Find Doctor: -- SELECT DOCTOR -- (dropdown)
- Name: [text input]
- Phone: [text input]
- Fax: [text input]
- Address: [text input]
- City: [text input]
- State: LA (dropdown)
- Zip: [text input]

At the bottom of the form, there is a status bar with the text "Automatic Refresh in 19 minutes and 24 seconds" and a "Local intranet" logo.

### ***Complete Screen***

Once all the required fields have been filled in and the form has been submitted, the user will receive a message that the Newborn Eligibility ID Assignment Request form has been successfully submitted.

If it was not successful for any reason, they will be returned to the input page to correct the problem.

The user will be given the option to continue to complete the Third Party Liability (TPL) Notification of Newborn Children form or resume later.

To resume completion of the Third Party Liability (TPL) Notification of Newborn Children later simply click the "Resume TPL" link in the left menu and select the form you wish to resume.

# CCN-P REQUEST FOR PROPOSALS

Department of Health and Hospitals  
Medicaid Program  
Request for Newborn Medicaid ID Number

Newborn Eligibility Unit

Log Out  
Start New Form  
Resume TPL Notification  
Your History  
Blank Newborn ID  
Blank TPL  
User Manual

**152N has been successfully submitted. Press Continue to fill out the LaHipp form.**

In accordance with the Department of Health and Hospitals, Third Party Liability-Newborn Notification Rule, the TPL Notification of Newborn Child(ren) form **shall be completed by the hospital and submitted within seven days of the birth of a newborn child.**

Continue Resume Later

If for some reason the user needs to correct information on the filing just submitted, they may click the back button and the previously entered data will be displayed on the screen, including the mother and child's information. It is important that this only be done to correct the previous filing and then resubmit. If the user is submitting a correction, they need to be sure to click the "2nd Request" option in the Child / Birth Information section to help identify updated filings.

NO

### Child / Birth Information

**Special Notes**

Twin A  **2nd Request** Other:

Twin B  Corrected Copy

Adoption  NICU

**Child's Name**

**Child's DOB**

## Third Party Liability (TPL) Notification of Newborn Children Form

### TPL Notification Input Screen

The TPL Notification of Newborn Children Input Screen like the Newborn Eligibility ID Assignment Request Input Screen provides a web interface for filling out the TPL Notification of Newborn Children form quickly by individual hospitals that have access to the system. Each field indicated in red is a required field. The user will notice that some fields already populated on the completed Newborn Eligibility ID Assignment Request form will automatically populate.

### Hospital Information

Hospital information may populate via information completed on the Newborn Eligibility ID Assignment Request form. Phone/fax fields are setup to allow for quick entry. Date fields require MM/DD/YYYY format. The Hospital Name, Contact Person and Phone Number are required.

Department of Health and Hospitals  
Medicaid Program  
Third Party Liability (TPL) Notification of Newborn Children

Newborn Eligibility Unit

Log Out  
Start New Form  
Resume TPL Notification  
Your History  
Blank Newborn ID  
Blank TPL  
User Manual

\* Fields in red indicate that they are required.

**Hospital Information**

Date

Hospital Name  Phone Number

Contact Person  Contact Person Email

Was the newborn delivered in your facility?  Yes  No Facility Provider No.

Admission Date of Newborn Child  Discharge Date

Attending Provider Name

Will the attending provider accept health insurance as Primary and Medicaid as Secondary?  Yes  No

Was the newborn discharged to another facility?  Yes  No

If yes, Facility Name:  Telephone No:

### Mother's Information

Some information on the mother will populate via the information already supplied on the Newborn Eligibility ID Assignment Request form. The user should verify populated information

## CCN-P REQUEST FOR PROPOSALS

for accuracy and update accordingly. Required information in this section includes whether the mother is currently covered by Medicaid or not and whether she will enroll the newborn into the available employer sponsored health insurance plan. Enrollment within many employer sponsored health plans must occur within thirty days of birth therefore accurate contact information is extremely important.

Mother's Information	
Name	<input type="text"/>
Date of Birth	<input type="text"/> SSN <input type="text"/>
Mailing Address	<input type="text"/>
City, State Zip	<input type="text"/> LA <input type="text"/>
Phone Number	<input type="text"/>
Is the mother covered by medicaid?	<input checked="" type="radio"/> Yes <input type="radio"/> No Applied? <input type="radio"/> Yes <input type="radio"/> No Date Applied <input type="text"/>
Will you enroll your newborn in your employer sponsored insurance plan?	<input type="radio"/> Yes <input type="radio"/> No
Mother's Employment	
Employer	<input type="text"/>
Telephone #	<input type="text"/>

### Father's Information

The father's name is the only required information within this section. The father can be the policyholder for the private insurance. Enrollment of the newborn within the employer sponsored health insurance may need to occur within thirty days of birth therefore accurate contact information is extremely important.

## CCN-P REQUEST FOR PROPOSALS

Father's Information	
Name	<input type="text"/>
Date of Birth	<input type="text"/> SSN <input type="text"/>
Mailing Address	<input type="text"/>
City, State Zip	<input type="text"/> <input type="text"/> <input type="text"/>
Phone Number	<input type="text"/>
Is the father covered under health insurance coverage?	<input type="radio"/> Yes <input type="radio"/> No
Name of Insurance Company	<input type="text"/>
Father's Employment	
Employer	<input type="text"/>
Telephone #	<input type="text"/>

### Newborn Information

Some information on the newborn(s) will automatically populate via the information supplied on the Newborn Eligibility ID Assignment Request form. The user should verify the accuracy of the newborn(s) name (first, last), date of birth, birth-weight (lbs, oz), and sex. Other information in this section needing verification includes whether the newborn(s) is adopted, NICU or multiple births. Accurate birth-weight in pounds and ounces is extremely important.

New Born #1					
Name on Birth Certificate					
First	<input type="text"/>	Middle	<input type="text"/>	Last	<input type="text"/>
Birth Date	<input type="text"/>	Birth Weight (lbs)	<input type="text"/>	(oz)	<input type="text"/>
Race	<input type="text"/>	Sex	<input checked="" type="radio"/> Male <input type="radio"/> Female	Births	<input type="radio"/> Single <input type="radio"/> Multiple
Gestation Age	<input type="text"/>	Adopted	<input type="radio"/> Yes <input checked="" type="radio"/> No	NICU	<input type="radio"/> Yes <input checked="" type="radio"/> No

### Insurance Plan Information

Hospitals are required to notify the Department of Health and Hospitals within seven days of the birth of any child who may meet eligibility provisions for the Medicaid Program. It is imperative that accurate information is obtained regarding insurance availability for the newborn child due to time constraints for enrollment within the insurance. Verification of insurance coverage for the mother is required. The following information pertaining to the insurance coverage for the

## CCN-P REQUEST FOR PROPOSALS

mother is also required. The name of the insurance company, address, phone number and the member and group number are all required. Primary and secondary (if applicable) plan information must be obtained. All required fields must be completed before successfully submitting the TPL Notification.

Health Insurance - Primary Plan	
Is mother covered under any health insurance coverage? <input checked="" type="radio"/> Yes <input type="radio"/> No	
(If the parent(s) have more than one insurance plan, please provide information related to the second plan below.)	
Name of Insurance Company	<input type="text"/>
Address	<input type="text"/>
City, State Zip	<input type="text"/> <input type="text"/> <input type="text"/>
Group No.	<input type="text"/> Member No. <input type="text"/>
Phone	<input type="text"/>
The Mother is the: <input type="radio"/> Employee <input type="radio"/> Dependent Spouse <input type="radio"/> Individual Policy Holder	
Health Insurance - Secondary Plan	
Name of Insurance Company	<input type="text"/>
Address	<input type="text"/>
City, State Zip	<input type="text"/> <input type="text"/> <input type="text"/>
Group No.	<input type="text"/> Member No. <input type="text"/>
Phone	<input type="text"/>
The Mother is the: <input type="radio"/> Employee <input type="radio"/> Dependent Spouse <input type="radio"/> Individual Policy Holder	
Insurance Notification	
Provide us with the address and name of person the insurance company that this notification will be mailed to:	
Company Name	<input type="text"/>
Contact Name	<input type="text"/>
Address	<input type="text"/>
City, State Zip	<input type="text"/> <input type="text"/> <input type="text"/>
Email Address	<input type="text"/>
Fax Number	<input type="text"/>
<input type="button" value="Submit"/>	

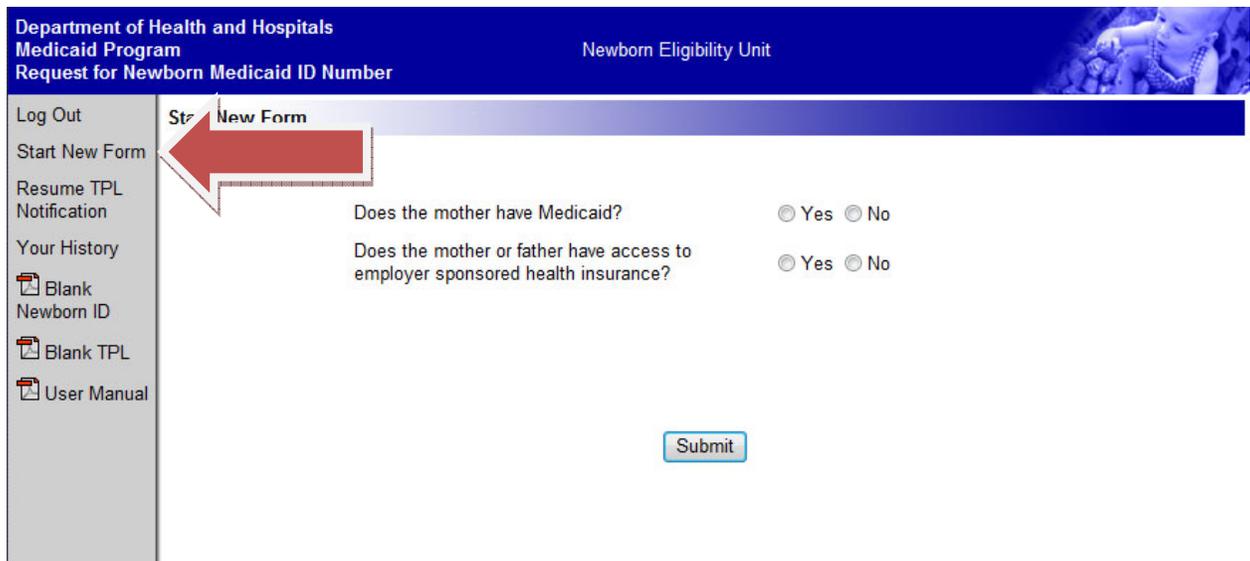
## Complete Screen

Once all the required fields have been completed and the form has been submitted, the user will be able to view or print the completed form. To view the completed form, the user may click on the “Click here to view the completed form” link on the success page. The form will be displayed as a PDF (Portable Document Format). In order to view PDF’s, the user must have Adobe Acrobat Reader installed on the local machine. The latest version of Acrobat Reader can be downloaded for free at:

<http://www.adobe.com/products/acrobat/readstep2.html>



The user can also click on the “Click here to start a new form”. This link will take you back to the Start Form page.



### Resume TPL Notification

This section allows you to resume the TPL process after you completed the Newborn Eligibility ID Assignment Request process. You can resume the form by clicking on the number in the open column.

Department of Health and Hospitals Medicaid Program Request for Newborn Medicaid ID Number		Newborn Eligibility Unit			
Log Out Start New Form Resume TPL Notification Your History Blank Newborn ID Blank TPL User Manual	Resume LaHipp Form				
	Open	Mother	Baby	Special Notes	Received
	201880	TEST , TEST	TEST , TEST		7/31/2008 9:27:16 PM
	201926	Hudson/Guillory , Mary	Guillory , Allyson		8/1/2008 1:40:16 PM
	201931	Janice , Wendy	Simon , Aiyanna		8/1/2008 1:52:13 PM
	201935	Janice , Wendy	Simon , Aiyanna		8/1/2008 1:59:21 PM
	201943	HERRING , VELMA	BYRUM , ANTOINAE		8/1/2008 2:33:02 PM
	201958	Garcia , Angelica	Hernandez , Angel		8/1/2008 3:02:00 PM
	201982	PETE , NATASHA	LEDET , TORIN		8/1/2008 4:09:13 PM
	201991	Andrews , Brandin	Knight , Rylan		8/2/2008 8:37:14 AM
	201996	Carter , Amber	Himel , Cadence		8/2/2008 12:07:15 PM
	201998	TEST , TEST	TEST , TEST		8/2/2008 1:55:08 PM
	201999	TEST , TEST	TEST , TEST		8/2/2008 2:15:47 PM

### Your History

This section allows you to review previous month's worth of filings. Simply click on the view link next to the filing information to view.

Department of Health and Hospitals Medicaid Program Request for Newborn Medicaid ID Number		Newborn Eligibility Unit		
Log Out Start New Form Resume TPL Notification Your History Blank Newborn ID Blank TPL User Manual	(This page displays the past month's filings)			
		Last Name	First Name	Submitted Date
	<a href="#">View</a>		TEST	08/06/2008
	<a href="#">View</a>	test	test	08/06/2008
	<a href="#">View</a>	ST	TEST	08/02/2008
	<a href="#">View</a>	ST	TEST	08/02/2008
	<a href="#">View</a>	TEST	TEST	08/02/2008
	<a href="#">View</a>		TEST	07/31/2008
	<a href="#">View</a>	W TEST	TEST	07/31/2008
	<a href="#">View</a>	TEST	TEST	07/31/2008
<a href="#">View</a>	TEST	TEST	07/31/2008	
1				

## Questions or Comments

Please submit any questions or comments that you may have regarding this system to the following:  
1-888-342-6207

## **Appendix T**

# **CCN Request for Member Disenrollment**

**CCN-P REQUEST FOR PROPOSALS**  
**CCN Request for Member Disenrollment**

To: Medicaid CCN Enrollment Broker

From: \_\_\_\_\_

\_\_\_\_\_ (CCN name) is requesting the member listed

below to be disenrolled from for the following reason: \_\_\_\_\_

Print the Name of Member (Last, First, Middle Initial)	Birth Date	Medicaid ID Number or Social Security Number	Requested Disenrollment Date

- Member has demonstrated a pattern of disruptive, unruly, abusive or uncooperative behavior to the extent that enrollment in the CCN seriously impairs the organization’s ability to furnish services to either the member or other members **and** the member’s behavior is not caused by a physical or mental condition. (Attach separate narrative with additional information including measures taken by the CCN to correct the member’s behavior prior to submitting the request for disenrollment)

- Member’s utilization of services is fraudulent or abusive (e.g. member loans the CCN issued ID card to another person to obtain services). (Attach narrative with additional information including date of referral to Medicaid Program Integrity’s Fraud Hotline)
- Member is placed in a long-term care nursing facility, ICF/DD facility, or becomes eligible for a Medicaid Home and Community-Based Services Waiver or hospice. Indicate which \_\_\_\_\_
- Member has died or is incarcerated. Date of death or incarceration \_\_\_\_\_
- Other \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The Louisiana Department of Health and Hospitals will determine if the CCN has shown a good cause to disenroll the Medicaid/CHIP member. The Enrollment Broker will give written notification to the CCN of the decision. Medicaid/CHIP members have the right to appeal disenrollment decisions and request a state fair hearing disenrollment to the Division of Administrative Law.

The CCN shall not discriminate against any Medicaid /CHIP member on the basis of their health status, need for health care services or any other adverse reason with regard to the member’s health, race, sex, handicap, age, religion or national origin.

## **Appendix U**

# **Guidelines for Member Disenrollment**

## CCN-P REQUEST FOR PROPOSALS

### Guidelines for Member Disenrollment

Generally the effective date of disenrollment from a CCN is prospective. Effective dates for other than routine disenrollments are described below.

<b>Member Disenrollment *</b>	
<b>Reason for Disenrollment</b>	<b>Disenrollment Effective Date</b>
Loss of Medicaid and CHIP eligibility	First day of month following Medicaid or CHIP case closure.
Death of member	First day of month following death. PMPM for months following the month of death will be recouped.
Intentional submission of fraudulent information	First day of earliest month allowed by system.
Member moved outside of GSA	First day of month after the update of the system with the new address in a different GSA.
Member moves out of state	First day of month after moving out state. Any PMPM payments for months following the month of the move will be recouped.
Member elects hospice	First day of the month following hospice election.
Member in LTC/NH	First day of the month following admission into NH.
Member elects Waiver Services	First day of the month following entry into waiver program.
Loss of CCN's participation	First day of month following CCN's termination date.
Member with more than one Medicaid Identification Number is enrolled in a CCN under more than one of the Medicaid Identification Numbers	First day of the month the duplicate enrollment began. Any duplicate PMPM payments will be recouped.
Incarceration	First day of the month following incarceration <i>Note- CCN is at risk for core benefits and services only to the date of incarceration</i>
Member enrolled in Medicare	First day of month following identification of Medicare coverage. Up to 12 retroactive months PMPM paid will be recouped.

## CCN-P REQUEST FOR PROPOSALS

<b>Member Disenrollment *</b>	
<b>Reason for Disenrollment</b>	<b>Effective Date of Disenrollment</b>
CCN request for disenrollment	First day of earliest month allowed by system edits following DHH approval.
Recipient on Inconsistent Parish Report	First day of earliest month allowed by system edits following verification of new address, if new address is in a different GSA.
Member status changes to Section 1115 Medicaid Family Planning Waiver only	If the status of the member changes while in the hospital to a category where the hospital and physician charges would not be paid under FFS, the patient would be responsible for both the facility and physician charges for the uncovered portion of the stay (from the date that their status changes to FP services only).
Member terminates with one CCN and joins another while in hospital (disenrollment/enrollment date occurs while in hospital)	The CCN that covers a member on the day of admission to a hospital will be responsible for the entire stay (facility charge), even if their CCN changes while they are inpatient. The date of service will dictate the responsible party for physician charges.
<p><i>*DHH policy allows special exceptions to the disenrollment provisions listed above when in the best interest of the member and/or the Medicaid program. These exceptions will be considered on a case by case basis.</i></p> <p><i>**Inmate is defined as a person incarcerated in or otherwise confined to a correctional institution (i.e., jail). This does not include individuals on Probation or Parole or who are participating in a community program.</i></p>	

## **Appendix V**

# **Fiscal Intermediary Payment Schedule**

## CCN-P REQUEST FOR PROPOSALS

### Louisiana Department of Health and Hospitals Medicaid CCN-P Payment Schedule

<b>Year</b>	<b>Month</b>	<b>EFT Date</b>	<b>Expected Date of Deposit</b>
2012	January	01/10/2012	01/11/2012
	February	02/14/2012	02/15/2012
	March	03/13/2012	03/14/2012
	April	04/10/2012	04/11/2012
	May	05/15/2012	05/16/2012
	June	06/12/2012	06/13/2012
	July	07/10/2012	07/11/2012
	August	08/14/2012	08/15/2012
	September	09/11/2012	09/12/2012
	October	10/09/2012	10/10/2012
	November	11/13/2012	11/14/2012
	December	12/11/2012	12/12/2012
2013	January	01/15/2013	01/16/2013
	February	02/12/2013	02/13/2013
	March	03/12/2013	03/13/2013
	April	04/09/2013	04/10/2013
	May	05/14/2013	05/15/2013
	June	06/11/2013	06/12/2013
	July	07/09/2013	07/10/2013
	August	08/13/2013	08/14/2013
	September	09/10/2013	09/11/2013
	October	10/15/2013	10/16/2013
	November	11/12/2013	11/13/2013
	December	12/10/2013	12/11/2013
2014	January	01/14/2014	01/15/2014
	February	02/11/2014	02/12/2014
	March	03/11/2014	03/12/2014
	April	04/15/2014	04/16/2014
	May	05/13/2014	05/14/2014
	June	06/10/2014	06/11/2014

## **Appendix W**

# **DHH Marketing and Member Education Materials for Approval Form**



CCN-P REQUEST FOR PROPOSALS

FOR DHH USE ONLY	
Submitted for (choose one)	Review <input type="checkbox"/>
	Approval <input type="checkbox"/>
Date Submitted by CCN	
Date of DHH Response (see below for response)	

Louisiana Coordinated Care Network Program

# Marketing and Member Education Materials Submission Form

## COORDINATED CARE NETWORK CONTACT INFORMATION

CCN Name/ Name of Person Submitting/ Title:		
Address:		GSA (s):
Phone:	E-mail:	Fax:

## MATERIAL DETAILS

Name of Material:		
Type of Material (check one): <input type="checkbox"/> Print Ad <input type="checkbox"/> Radio Ad <input type="checkbox"/> TV Ad <input type="checkbox"/> Billboard <input type="checkbox"/> Flyer <input type="checkbox"/> Newsletter <input type="checkbox"/> News Release <input type="checkbox"/> Poster <input type="checkbox"/> Bus board <input type="checkbox"/> Website <input type="checkbox"/> Promotional Item <input type="checkbox"/> Phone Script <input type="checkbox"/> Brochure <input type="checkbox"/> Sign <input type="checkbox"/> Handbook <input type="checkbox"/> Directory <input type="checkbox"/> Other: _____		
Purpose or Goal of the Material: <input type="checkbox"/> Marketing <input type="checkbox"/> Member Education		

## DISTRIBUTION PLAN FOR MATERIAL

Target Audience for Material: <input type="checkbox"/> Members <input type="checkbox"/> Providers <input type="checkbox"/> General Public <input type="checkbox"/> Other: _____	
Quantity or Impressions: <i>(number of materials to be printed/distributed or in the case of broadcast, the number of planned impressions)</i>	
Distribution Plan for Material: <i>(should illustrate equitable distribution plan for the service area – attach additional pages as needed)</i>	
Map or explanation of service area attached: <input type="checkbox"/>	Media Buy Documentation Attached: <input type="checkbox"/>
References to CCN Marketing and Member Education Plan: <i>(if not included in the most current Plan on file with DHH, a revised version of the Plan must be submitted as well)</i>	

## DHH RESPONSE

<b>First Draft</b> <input type="checkbox"/> Make changes and return to DHH <input type="checkbox"/> Approved with changes <input type="checkbox"/> Approved for printing/publication	<b>First Draft</b> <input type="checkbox"/> Make changes and return to DHH <input type="checkbox"/> Approved with changes <input type="checkbox"/> Approved for printing/publication	<b>First Draft</b> <input type="checkbox"/> Make changes and return to DHH <input type="checkbox"/> Approved with changes <input type="checkbox"/> Approved for printing/publication
DHH Signature:	DHH Signature:	DHH Signature:
Date:	Date:	Date:

# **Appendix X**

## **DHH Event Submission Form**



FOR DHH USE ONLY	
Date Submitted by CCN	
Date of DHH Response (see below for response)	

Louisiana Coordinated Care Network Program  
**Event Submission Form**

**COORDINATED CARE NETWORK CONTACT INFORMATION**

CCN Name/ Name of Person Submitting/ Title:		
Address:		GSA (s):
Phone:	E-mail:	Fax:

**EVENT HOST INFORMATION**

Event Host Organization or Business:	Event Host Contact: <i>(Name and Title)</i>
Event Host Phone Number:	Event Host E-mail:

**EVENT DETAILS**

Name of Event:	Date of Event:	Time of Event:
Event Location: <i>(City, Parish and DHH Region, GSA)</i>	<b>Type of Event:</b> <input type="checkbox"/> Presentation <input type="checkbox"/> Community Event <input type="checkbox"/> Health Fair <input type="checkbox"/> Other: _____	

**Target Audience for Event:**  
 Members     Providers     General Public     Other: \_\_\_\_\_

**Brief Description of Event:**

**Materials to be Distributed at Event:**

**Marketing Event References to CCN Marketing Plan:** *(if not included in the most current Marketing Plan on file with DHH, a revised version of the CCN Marketing Plan must be submitted as well)*

**DHH RESPONSE**

<b>Approval Response:</b>  <input type="checkbox"/> Event Approved <input type="checkbox"/> Event Not Approved <input type="checkbox"/> Further Detail Needed	<b>Additional Details Needed:</b>  
---	---

**DHH Signature:**

**Date:**

# **Appendix Y**

**Reserved**

## **Appendix Z**

# **DHH Marketing Complaint Form**



FOR DHH USE ONLY	
STAGE OF REVIEW	DATE
<input type="checkbox"/> Form Received at DHH	
<input type="checkbox"/> Investigation Begins	
<input type="checkbox"/> Sanctions Applied	
<input type="checkbox"/> Response Sent to Complainant	
<input type="checkbox"/> Investigation Closed	

Louisiana Coordinated Care Network Program  
**Marketing Complaint Form**

**COMPLAINANT CONTACT INFORMATION**

Complainant Name/ Title/Organization:

Address:

Phone: E-mail: Fax:

**COMPLAINT DETAILS**

Parties to the Alleged Violation: *(violator, witnesses and others)*

Date/Time/Frequency of Alleged Violation:

Location of Alleged Violation: *(facility name including location - address, unit, room, floor)*

Narrative/specifics of alleged violation: *(Please attach any documentation to support this allegation and attach additional pages if more space is needed for the narrative)*

Why is this alleged violation a violation of the Marketing Policy and Procedures? Please include citations to specific policies and procedures?

What harm has resulted due to this alleged violation? *(such as misrepresentation, unfair advantage gained)*

What is the complainant's expectation/desire for resolution/remedy, if any?

**DHH INVESTIGATION NOTES**

DHH Investigator Signature:  
*(at completion of investigation)*

Print Name: Date:

## **Appendix AA**

# **Member's and Potential Member's Bill of Rights**

### **Louisiana Medicaid Coordinated Care Network Program Member's and Potential Member's Bill of Rights**

Each member is guaranteed the following rights:

- To be treated with respect and with due consideration for his/her dignity and privacy.
- To participate in decisions regarding his/her health care, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To be able to request and receive a copy of his/her medical records, (one copy free of charge) and request that they be amended or corrected.
- To receive health care services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- To receive all information — e.g., enrollment notices, informational materials, instructional materials, available treatment options and alternatives — in a manner and format that may be easily understood as defined in the Contract between DHH and the CCN.
- To receive assistance from both DHH and the Enrollment Broker in understanding the requirements and benefits of the CCN.
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To be notified that oral interpretation is available and how to access those services.
- As a potential member, to receive information about the basic features of the CCN program; which populations may or may not enroll in the program and the CCN's responsibilities for coordination of care in a timely manner in order to make an informed choice.
- To receive information on the CCN's services, to include, but not limited to:
  - Benefits covered
  - Procedures for obtaining benefits, including any authorization requirements
  - Any cost sharing requirements
  - Service area

## CCN-P REQUEST FOR PROPOSALS

- Names, locations, telephone numbers of and non-English language spoken by current contracted providers, including at a minimum, primary care physicians, specialists, and hospitals
  - Any restrictions on member's freedom of choice among network providers
  - Providers not accepting new patients
  - Benefits not offered by the CCN but available to members and how to obtain those benefits, including how transportation is provided
- To receive a complete description of disenrollment rights at least annually.
  - To receive notice of any significant changes in core benefits and services at least 30 days before the intended effective date of the change.
  - To receive information on grievance, appeal and State Fair Hearing procedures.
  - To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
    - What constitutes an emergency medical condition, emergency services, and post-stabilization services
    - That emergency services do not require prior authorization
    - The process and procedures for obtaining emergency services
    - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract
    - Member's right to use any hospital or other setting for emergency care
    - Post-stabilization care services rules as detailed in 42 CFR §422.113(c)
  - To receive the CCN's policy on referrals for specialty care and other benefits not provided by the member's PCP.
  - To have his/her privacy protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 Subparts A and E, to the extent that they are applicable.
  - To exercise these rights without adversely affecting the way the CCN, its providers or DHH treat the member.

## **Appendix BB**

# **DHH Marketing Plan Monthly Report**

**(To be established)**

## **Appendix CC**

# **Grievance and Appeal and Fair Hearing Log Report**

## CCN-P REQUEST FOR PROPOSALS

20__ Coordinated Care Network Grievances and Appeals Reporting	
<b>I. Contact Information</b>	
Date:	
Coordinated Care Network Name:	
Contact Name:	
Contact Title:	
Address:	
<b>Telephone Numbers:</b>	
Local:	
Toll Free:	
E-mail Address:	
Name of IRO(s):	
(If CCN has more than 3 IROs, please attach a separate sheet.)	

## CCN-P REQUEST FOR PROPOSALS

### 20\_\_ Coordinated Care Network Grievances and Appeals Report

#### II. Review Activities

	Grievances	Appeals	State Fair Hearings
Number of grievances/appeals reviewed:			
Number of grievances/appeals resolved:			
*Percentage of overturned decisions:			
Number still pending at the end of 20__:			
Number of grievances/appeals considered ineligible:			
Average length of time to complete each grievances/appeals process:			
Number of cases where CCN reversed its decision in the member's favor:			
* In cases where the decision was overturned in the member's favor, what was the most common reason? (e.g. availability of new information):			
List the top 5 services that were most commonly the subject of grievances/appeals (e.g., emergency room care, durable medical equipment).			
1			
2			
3			
4			
5			
List the top 5 issues resulting in referral to an independent review organizations for appeal.			
1			
2			
3			
4			
5			







**CCN-P REQUEST FOR PROPOSALS**

<b>Grievances and Appeal Reason Summary Chart</b>				
<b>Appeal / Denial Reason Number Code</b>	<b>Appeal / Denial Reason</b>	<b>Number of Grievances</b>	<b>Number of Appeals</b>	<b>Number of State Fair Hearing Appeals</b>
1	<b>Benefit Limitation/Exclusion</b>			
2	<b>Clinical Criteria Not Met - Assistant Surgeon</b>			
3	<b>Clinical Criteria Not Met - Durable Medical Equipment</b>			
4	<b>Clinical Criteria Not Met - Inpatient Admissions</b>			
5	<b>Clinical Criteria Not Met - Medical Procedure</b>			
6	<b>Authorization</b>			
7	<b>Lack of Information from Provider</b>			
8	<b>Level of Care Dispute</b>			
9	<b>Out of Network Benefit</b>			
10	<b>Other</b>			
<b>TOTALS</b>				
<b>DO NOT ADD OR CHANGE REASON CODES</b>				

# **Appendix DD**

## **Performance Improvement Projects**

**CCN-P REQUEST FOR PROPOSALS**

<b>Performance Improvement Projects (PIPs)</b>		
<b>Section 1</b>	<b>Minimum Threshold</b>	<b>Specifications</b>
Ambulatory Care Measure – ED Visit category - The number of ED visits per 1000 member months	2011 Medicaid NCQA Quality Compass at or below the 50 <sup>th</sup> Percentile	HEDIS
<b>Section 2</b>	<b>Minimum Threshold</b>	<b>Specifications</b>
Cervical CA Screening - The percentage of women 24-64 years old in the denominator that received a cervical CA screening	2011 Medicaid NCQA Quality Compass at or above the 50 <sup>th</sup> Percentile	HEDIS
Breast CA Screening – The percentage of women 40-69 years old that received a breast CA screening	2011 Medicaid NCQA Quality Compass at or above the 50 <sup>th</sup> Percentile	HEDIS
Well Child Visits in the First 15 Months of Life – The percentage of children in the denominator that received at least 6 well child visits in the first 15 months of life	2011 Medicaid NCQA Quality Compass at our above the 50 <sup>th</sup> Percentile	HEDIS
Childhood Immunization Status (CIS) The percentage of children two years of age who had the appropriate immunizations by their second birthday (Combination 2)	2011 Medicaid NCQA Quality Compass at our above the 50 <sup>th</sup> Percentile	HEDIS
Elective Delivery Prior to 39 completed weeks gestation	Facility level	JCAHO
Cesarean Delivery Rate (nullipara)	Facility level	JCAHO
Elective Delivery	Facility level	JCAHO
Appropriate Use of Antenatal Steroids	Facility level	JCAHO
Exclusive Breastfeeding at Hospital Discharge	Facility level	JCAHO

## **Appendix EE**

# **Coordination of CCN Fraud and Abuse Complaints and Referrals**

## Louisiana Medicaid CCN Program

### **Coordination of CCN Fraud and Abuse Complaints and Referrals**

The following set of policies and procedures has been developed to govern the disposition of fraud and abuse complaints along with the coordination of activities between DHH and Coordinated Care Networks (CCNs). Their purpose is to establish policy for coordination and referral of complaints made against healthcare providers providing services under a CCN and members enrolled in a CCN, in accordance with 42 CFR §455.

The Program Integrity Section and the Medicaid Coordinated Care Section will work jointly with the CCNs providing services to the Louisiana Medicaid and CHIP populations in order to ensure that all complaints for fraud and abuse are reviewed and investigated in a timely manner and that fraud referrals are made when appropriate. DHH receives fraud and abuse complaints via four main mechanisms:

- The Medicaid fraud hotline toll free number, 1-800-488-2917;
- U.S. mail, Program Integrity Section, P.O. Box 91030, Baton Rouge, LA 70821;
- Fraud reporting fax line 225-219-4155; or
- DHH's website [www.dhh.louisiana.gov/offices/?ID=92](http://www.dhh.louisiana.gov/offices/?ID=92) and click on the "Report fraud, abuse or complaints" button.

#### **Coordination Involving Fraud and Abuse Complaints Received by DHH**

- If DHH receives a complaint about a CCN member's **eligibility** for Medicaid/CHIP, the complaint is referred within three business days to the Medicaid Eligibility Field Operations Section.
- If DHH receives a complaint about a CCN member's **utilization of benefits**, the complaint is referred within three business days to the appropriate CCN.
- If DHH receives a complaint about a provider contracted with CCN(s), the complaint is referred to Program Integrity and Medicaid Coordinated Care Section for preliminary screening for fraud and abuse and/or referral to the appropriate CCN(s) for action.

#### **Coordination for Fraud and Abuse Complaints Received by CCN**

- If the CCN receives a complaint about a member's eligibility for Medicaid/CHIP, the complaint is referred to the Program Integrity Section. The referral is made within three business days.
- If the CCN receives a complaint about a member's utilization of benefits, the complaint is handled internally in accordance with the CCN's fraud and abuse/program integrity plan.
- If the CCN receives a complaint against a health care provider or contractor in its network, the CCN shall investigate in accordance with its fraud and abuse/ program integrity plan.

## CCN-P REQUEST FOR PROPOSALS

- The CCN will be required to capture data on complaints they receive and shall send reports to Program Integrity monthly.

### **Fraud and Abuse Referrals**

- If a complaint or the findings of a preliminary investigation give the CCN reason to believe that fraud or abuse of the Medicaid program has occurred, the CCN must report this information to the Program Integrity Section within three (3) business days using one of the four mechanisms described above. Any suspicion or knowledge of fraud and abuse includes, but is not limited to, the false or fraudulent filings of claims and the acceptance or failure to return monies allowed or paid on claims known to be fraudulent, on the part of members, employees, providers, or contractors. The CCN should submit all relevant information about the case, including its findings and the details of its investigation through one of the four mechanisms DHH receives complaints.
- Upon suspicion of Medicaid fraud on the part of a member enrolled in a CCN, the CCN will refer the complaint to the Program Integrity Section within three (3) business days with all supporting evidence. .
- The Medicaid Coordinated Care Section will send a copy to Program Integrity of any fraud and abuse reports received from the CCNs within three (3) business days.
- For fraud cases against providers and members either initiated or referred by other Offices within DHH, the Office will inform the CCN and the Medicaid Coordinated Care Section when the case results in a criminal conviction, sanction, loss of benefits, and/or exclusion from the Medicaid program.

### **Excluded Providers**

- The Program Integrity Section will update the Health Care Integrity and Protection Databank (HIPDB) to reflect all permissive and mandatory provider exclusions. The CCN shall be required to query the HIPDB for excluded providers. DHH will allow the CCN to become an authorized agent in order for the CCN to gain access to the HIPDB. Information concerning the data bank can be located at: <http://www.npdb-hipdb.hrsa.gov/index.jsp>
- CCNs shall also check the Excluded Parties List System ([www.EPLS.gov](http://www.EPLS.gov)) website and the Office of Inspector General Exclusion Database (<http://exclusions.oig.hhs.gov/search.aspx>) for excluded providers.

### **Information Sharing**

The CCN's Compliance Offer will meet with the DHH Program Integrity Unit and Attorney General's Medicaid Fraud Control Unit (MFCU) on a quarterly basis to exchange information and collaboration on suspected fraud and abuse occurrences. These meetings may take place in person or via teleconference.

**Appendix FF**

**CCN Provider and Subcontractor  
Listing**

## CCN-P REQUEST FOR PROPOSALS

### CCN Network Provider Subcontractor Listing Spreadsheet Requirements

Please provide the following information regarding all Medicaid enrolled network providers:

1. Practitioner Last Name, First Name and Title - For types of service such as primary care providers and specialist, list the practitioner's name and practitioner title such as MD, NP (Nurse Practitioner), PA (Physician Assistant), etc.
2. Practice Name/Provider Name - Indicate the name of the provider. For practitioners indicate the professional association/group name, if applicable.
3. Business Location Address - Indicate the business location address where services are provided including but not limited to, 1<sup>st</sup> line of address, 2<sup>nd</sup> line of address, City, State, Postal Code and Telephone Numbers (office and fax).
4. License Number - Indicate the provider/practitioner license number, if appropriate.
5. Medicaid Provider Number – Indicated the provider/practitioner's Medicaid provider number, if they are a Medicaid provider.
6. Provider Type and Specialty Code - Indicate the practitioner's specialty using the attached Medicaid Provider Type and Specialty Codes.
7. New Patient - Indicate whether or not the provider is accepting new patients.
8. Age Restriction - Indicate any age restrictions for the provider's practice. For instance, if a physician only sees patients up to age 19, indicate < 19; if a physician only sees patients age 13 or above, indicate ≥ 13.
9. Contract Name/Number – Indicate which CCN subcontract the physician is associated with. Example: If the contract is for a group practice, all physicians within the group will have the same contract name/number.
10. Contract Begin Date – Indicate the date the contract became effective.
11. Contract Termination Date – Indicate the date the contract ended.
12. Parish Served – Indicate which parish or parishes the provider serves. Do so by listing all 64 parishes in alphabetical order (one column per parish) and placing an "X" in each appropriate column, indicating that the provider serves that parish. For example, if the provider has offices in 3 parishes, but is used by the CCN to provide services in 6 parishes, place an "X" in the columns of each of the 6 parishes served.

On separate tabs to the spreadsheet, please provide listings of all 1) new and 2) terminated providers for the month. For these tabs, please provide the information requested in items 1-12 above.

**Appendix GG**

**CCN Disenrollment Report**

**(To be established)**

# **Appendix HH**

## **EPSDT Reporting**

## CCN-P REQUEST FOR PROPOSALS

### 2700.4 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416)

A. Purpose -- The annual EPSDT report (form CMS-416) provides basic information on participation in the Medicaid child health program. The information is used to assess the effectiveness of State EPSDT programs in terms of the number of children (by age group and basis of Medicaid eligibility) who are provided child health screening services, referred for corrective treatment, and receiving dental services. Child health screening services are defined for purposes of reporting on this form as initial or periodic screens required to be provided according to a state's screening periodicity schedule.

The completed report demonstrates the State's attainment of its participation and screening goals. Participant and screening goals are two different standards against which EPSDT participation is measured on the form CMS-416. From the completed reports, trend patterns and projections are developed for the nation and for individual states or geographic areas, from which decision and recommendations can be made to ensure that eligible children are given the best possible health care. The information is also used to respond to congressional and public inquiries.

B. Reporting Requirement -- Each State that supervises or administers a medical assistance program under Title XIX of the Social Security Act must report annually on form CMS-416. This data must include services provided under both fee-for-service and capitated managed care arrangements. Each State is required to collect encounter data (or other data as necessary) from managed care entities in sufficient detail to provide the information required by this report. You may contact your CMS regional office EPSDT specialist if you need technical assistance in completing this form.

C. Effective Date -- The form CMS-416 effective date was April 1, 1990. The first full fiscal year for which the form was effective began October 1, 1990. This version of the form must be used effective fiscal year 2010 for data due on or after April 1, 2011.

D. Submittal Procedure -- States should submit the annual form CMS-416 and your State periodicity schedule electronically to the CMS central office via the EPSDT mailbox at [EPSDT@cms.hhs.gov](mailto:EPSDT@cms.hhs.gov) not later than April 1 of the year following the end of the Federal fiscal year being reported. The electronic form and instructions are available on the CMS website at [http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/03\\_StateAgencyResponsibilities.asp#TopOfPage](http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp#TopOfPage). States may not modify the electronic form. It must be submitted as downloaded. A "hard copy" submittal to CMS is no longer required.

E. Detailed Instructions -- For each of the following line items, report total counts by the age groups indicated and by whether categorically and medically needy. In cases where calculations are necessary, perform separate calculations for the total column and each age group. **Report age based upon the child's age as of September 30.**

**State.** Enter the name of your State using two character State code in upper case format.

## CCN-P REQUEST FOR PROPOSALS

**Fiscal Year.** Enter the Federal fiscal year (FY) being reported in YYYY format.

**Line 1a – Total Individuals Eligible for EPSDT** – Enter the total unduplicated number of individuals under the age of 21 enrolled in Medicaid or a Children’s Health Insurance Program (CHIP) Medicaid expansion program determined to be eligible for EPSDT services, distributed by age (based on age as of September 30) and by basis of eligibility. “Unduplicated” means that an eligible person is reported only once although he/she may have had more than one period of eligibility during the year. Include all individuals regardless of whether the services are provided under fee-for-service arrangements or managed care arrangements. States should determine the basis of eligibility consistent with the instructions for form CMS-2082. Medicaid-eligible individuals under age 21 are considered eligible for EPSDT services regardless of whether they have been informed about the availability of EPSDT services or whether they accept EPSDT services at the time of informing. Individuals for whom third-party liability is available should also be counted in the number.

Do not include in this count the following groups of individuals: 1) medically needy individuals under the age of 21 if you do not provide EPSDT services for the medically needy population; 2) individuals eligible for Medicaid only under a §1115 waiver as part of an expanded population for which the full complement of EPSDT services is not available; 3) undocumented aliens who are eligible only for emergency Medicaid services; 4) children in separate State CHIP programs; or 5) other groups of individuals under age 21 who are eligible only for limited services as part of their Medicaid eligibility (i.e., pregnancy-related services).

**Line 1b -- Total Individuals Eligible for EPSDT for 90 Continuous Days** -- Enter the total unduplicated number of individuals under the age of 21 from line 1a who have been continuously enrolled in Medicaid or a CHIP Medicaid expansion program for at least 90 days in the Federal fiscal year and determined to be eligible for EPSDT services, distributed by age and by basis of eligibility.

**Line 1c – Total Individuals Eligible for EPSDT under a CHIP Medicaid Expansion Program** – Enter the number of individuals **included in line 1b** who are under the age of 21 and eligible for EPSDT services as part of a CHIP Medicaid expansion program. For children who have been eligible for EPSDT under both Medicaid and a CHIP Medicaid expansion program during the report year, include the child on this line if they are enrolled in CHIP as of September 30.

**Line 2a - State Periodicity Schedule** -- Enter the number of initial or periodic general health screenings required to be provided to individuals within the age group specified according to the State’s periodicity schedule. (Example: If your State periodicity schedule requires screening at 12, 18 and 24 months, the number 3 should be entered in the 1-2 age group column.) **Make no entry in the total column.**

**Note: Use the State’s most recent periodicity schedule and attach a copy to the completed report for submittal to CMS.**

## CCN-P REQUEST FOR PROPOSALS

**Line 2b - Number of Years in Age Group -- Make no entries on this line.** This is a fixed number reflecting the number of years included in each age group.

**Line 2c - Annualized State Periodicity Schedule --** Divide line 2a by the number in line 2b. Enter the quotient. This is the number of screenings expected to be received by an individual in each age group in one year. **Make no entry in the total column.**

**Line 3a - Total Months of Eligibility --** Enter the total months of eligibility for the individuals in each age group in line 1b during the reporting year. A child should only be counted once in the age group the child is in as of September 30. However, a child may have months of eligibility in two different age groups. Eligibility should be counted in the age group the child belonged to during the majority of that month. For example, if a child was eligible from May through September but turned three (3) on August 25th, four months of eligibility (May through August) are counted in the 1-2 age group and one month (September) are counted in the 3-5 age group. The child would be counted once on line 1b in the 3-5 age group (age as of September 30<sup>th</sup>).

**Line 3b - Average Period of Eligibility --** Divide line 3a by the number in line 1b. Divide that number by 12 and enter the quotient. This number represents the portion of the year that individuals remain Medicaid eligible during the reporting year.

**Line 4 - Expected Number of Screenings per Eligible --** Multiply line 2c by line 3b. Enter the product. This number reflects the expected number of initial or periodic screenings per child per year based on the number required by the State-specific periodicity schedule and the average period of eligibility. **Make no entries in the total column.**

**Line 5 - Expected Number of Screenings --** Multiply line 4 by line 1b. Enter the product. This reflects the total number of initial or periodic screenings expected to be provided to the eligible individuals in Line 1b.

**Line 6 - Total Screens Received -** Enter the total number of initial or periodic screens furnished to eligible individuals on line 1b under either fee-for-service or managed care arrangements based on date of service.

**Note: States may use the CPT codes listed below as a proxy for reporting these screens. Use of these proxy codes is for reporting purposes only. States must continue to ensure that all five age-appropriate elements of an EPSDT screen, as defined by law, are provided to EPSDT recipients.**

This number should not reflect sick visits or episodic visits provided to children unless an initial or periodic screen was also performed during the visit. However, it may reflect a screen outside of the normal State periodicity schedule that is used as a "catch-up" EPSDT screening. (A catch-up EPSDT screening is defined as a complete screening that is provided to bring a child up-to-date with the State's screening periodicity schedule. For example, a child who did not receive a periodic screen at age five visits a provider at age 5 years and 4 months. The provider may use that visit to provide a complete age appropriate screening and the screening may be counted on

## CCN-P REQUEST FOR PROPOSALS

the CMS-416.) Report data reflecting date of service within the fiscal year for such screening services or other documentation of such services furnished under capitated arrangements. The codes to be used to document the receipt of an initial or periodic screen are as follows:

### **CPT-4 codes: Preventive Medicine Services \***

99381 New Patient under one year  
99382 New Patient (ages 1-4 years)  
99383 New Patient (ages 5-11 years)  
99384 New Patient (ages 12-17 years)  
99385 New Patient (ages 18-39 years)  
99391 Established patient under one year  
99392 Established patient (ages 1-4 years)  
99393 Established patient (ages 5-11 years)  
99394 Established patient (ages 12-17 years)  
99395 Established patient (ages 18-39 years)  
99460 Initial hospital or birthing center care for normal newborn infant  
99461 Initial care in other than a hospital or birthing center for normal newborn infant  
99463 Initial hospital or birthing center care of normal newborn infant (admitted/  
discharged same date)

\*These CPT codes do not require use of a “V” code.

or

### **CPT-4 codes: Evaluation and Management Codes \*\***

99202-99205 New Patient  
99213-99215 Established Patient

\*\* These CPT-4 codes must be used in conjunction with codes V20-V20.2, V20.3, V20.31 and V20.32 and/or V70.0 and/or V70.3-70.9.

**Line 7 - Screening Ratio** - Divide the actual number of initial and periodic screening services received (line 6) by the expected number of initial and periodic screening services (line 5). This ratio indicates the extent to which EPSDT eligibles receive the number of initial and periodic screening services required by the State's periodicity schedule, prorated by the proportion of the year for which they are Medicaid eligible.

**Note: In calculating Line 7, if the number exceeds 100 percent, enter 1.0 in this field.**

**Line 8 - Total Eligibles Who Should Receive at Least One Initial or Periodic Screen** - The number of persons who should receive at least one initial or periodic screen is dependent on each State's periodicity schedule. Use the following calculations:

1. Look at the number entered in line 4 of this form. If that number is greater than 1, use the number 1. If the number on line 4 is less than or equal to 1, use the number in line 4. (This

## CCN-P REQUEST FOR PROPOSALS

procedure will eliminate situations where more than one visit is expected in any age group in a year.).

2. Multiply the number from calculation 1 above by the number in line 1b of the form. Enter the product on line 8.

**Line 9 - Total Eligibles Receiving at Least One Initial or Periodic Screen** - Enter the unduplicated count of individuals from line 1b, including those enrolled in managed care arrangements, who received at least one documented initial or periodic screen during the year.  
**Refer to codes in line 6.**

**Line 10 - Participant Ratio** - Divide line 9 by line 8. Enter the quotient. This ratio indicates the extent to which eligibles are receiving any initial and periodic screening services during the year.

**Note: In calculating Line 10, if this number exceeds 100 percent, enter 1.0 in this field.**

**Line 11 - Total Eligibles Referred for Corrective Treatment** - Enter the unduplicated number of individuals on line 1.b, including those in managed care arrangements, who, as the result of at least one health problem identified during an initial or periodic screening service, including vision and hearing screenings, were referred for another appointment with the screening provider or referred to another provider for further needed diagnostic or treatment services. This element does not include correction of health problems during the course of a screening examination.

**Line 12a - Total Eligibles Receiving Any Dental Services** - Enter the unduplicated number of children receiving at least one dental service by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (CDT codes D0100 - D9999).

**Line 12b - Total Eligibles Receiving Preventive Dental Services** - Enter the unduplicated number of children receiving at least one preventive dental service by or under the supervision of a dentist as defined by HCPCS codes D1000 - D1999 - (CDT codes D1000 - D1999).

**Line 12c - Total Eligibles Receiving Dental Treatment Services** - Enter the unduplicated number of children receiving at least one treatment service by or under the supervision of a dentist, as defined by HCPCS codes D2000 - D9999 (CDT codes D2000 - 09999).

**Line 12d – Total Eligibles Receiving a Sealant on a Permanent Molar Tooth --** Enter the unduplicated number of children in the age categories of 6-9 and 10-14 who received a sealant on a permanent molar tooth regardless of whether the sealant was provided by a dentist or a non-dentist, as defined by HCPCS code D1351 (CDT code D1351).

**Line 12e – Total Eligibles Receiving Diagnostic Dental Services –** Enter the unduplicated number of children receiving at least one diagnostic dental service by or under the supervision of a dentist, as defined by HCPCS codes D0120 – D0180 (CDT codes D0120 – D0180).

## CCN-P REQUEST FOR PROPOSALS

### **12f – Total Eligibles Receiving Oral Health Services Provided by a Non-Dentist Provider --**

Enter the unduplicated number of children receiving at least one oral health service as defined a HCPCS or CDT code furnished by a licensed practitioner that is not a dentist. For example, a pediatrician that applies a fluoride varnish or an independently practicing dental hygienist not under the supervision of a dentist furnishing a prophylaxis. These are only examples and are not intended to limit your reporting. NOTE: Due to the variance in State Practice Acts some States may not have data to report on this line.

**12g – Total Eligibles Receiving any Dental or Oral Health Service --** Enter the unduplicated number of children who received a dental service by or under the supervision of a dentist or an oral health service by a non-dentist. A child should only be counted **once** on this line even if the child received a dental service and an oral health service.

NOTES FOR LINE 12 DATA: For purposes of reporting the information on dental services in Lines 12a – 12g, use the total eligible individuals from line 1b. “Unduplicated” means that a child may only be counted once for each line of data. A child may be counted on two or more lines. For example, a child is counted once on line 12a for receiving any dental service, counted again on line 12c for receiving a dental treatment service and, if applicable, counted again on line 12f for receiving an oral health service by a non-dentist. These numbers should reflect services provided under both fee-for-service and managed care arrangements and through any other private health plans that contract with the State. We refer to “dental services” when referring to services provided by or under the supervision of a dentist. We refer to “oral health services” when the service is not provided by or under the supervision of a dentist.

**Line 13 - Total Eligibles Enrolled in Managed Care** - This number is reported for informational purposes only. This number represents all individuals eligible for EPSDT services in your State who are enrolled in any type of managed care arrangement at any time during the reporting year. It includes any capitated arrangements such as health maintenance organizations or individuals assigned to a primary care provider or primary care case manager regardless of whether reimbursement is fee-for-service or capitated. Include these individuals in the total number of eligibles on line 1a and b, as appropriate; include the number of initial or periodic screenings provided to these individuals in lines 6 and 8 for purposes of determining the State's screening and participation rates. The number of individuals referred for corrective treatment and receiving dental services are reflected in lines 11 and 12, respectively.

**Line 14 - Total Number of Screening Blood Lead Tests** - Enter the total number of screening blood lead tests furnished to eligible individuals under fee-for-service or managed care arrangements. **Follow-up blood tests performed on individuals who have been diagnosed with or are being treated for lead poisoning should not be counted. You may use one of two methods, or a combination of these methods, to calculate the number of blood lead screenings provided:**

- 1) **Count the number of times CPT code 83655 (“lead”) for a blood lead test is reported within certain ICD-9-CM codes (see Note below); or**

## CCN-P REQUEST FOR PROPOSALS

- 2) You may include data collected from use of the HEDIS®<sup>1</sup> measure developed by the National Committee for Quality Assurance to report blood lead screenings if your State had elected to use this performance measure.**

NOTE: On a claim, CPT code 83655 is the procedure code used to identify that a blood lead test was performed. CPT code 83655, when accompanied on the claim by a diagnosis code of V15.86 (exposure to lead) or V82.5) (special screening for other conditions such as a screening for heavy metal poisoning) may be used to identify a person receiving a screening blood lead test. However, a claim in which the procedure code 83655 is accompanied by a diagnosis code of 984(.0-.9) (toxic effect of lead and its compounds) or e861.6 (accidental poisoning by lead paints) would generally indicate that the person receiving the blood lead test had already been diagnosed or was being treated for lead poisoning and should not be counted.

F. Disclosure Statement - According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0354. The time required to complete this information collection is estimated to average 28 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop: C4-26-05, Baltimore, Maryland 21244-1850.

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<sup>1</sup> Health Effectiveness Data and Information Set

## **Appendix II**

# **Model Attestation Letter for Reports**

**CCN Model Attestation Letter for Reports**

(Company Letter Head)

Attestation for Reports

Date \_\_\_\_\_

I, \_\_\_\_\_, as (Title) for (Name of Company), do hereby attest, based upon my best knowledge, information and belief, that the data provided in the \_\_\_\_\_ Report(s) is accurate, true, and complete.

I understand that should DHH determine the submitted information is inaccurate, untrue, or incomplete, (Name of company) may be subject to monetary penalties or sanctions and/or fines as outlined in SECTION 18 of the Contract.

\_\_\_\_\_  
Signature/Title

\_\_\_\_\_  
Date

# **Appendix JJ**

## **Transition Period Requirements**

## **Transition Period Requirements**

### **Introduction**

This Section presents the scope of work for the Transition period of the Contract, which includes those activities that must take place between the time of Contract award and the Go-Live Date.

Each CCNs Go-Live Date will be determined by DHH once requirements are met.

The Transition Period will include a Readiness Review of each CCN, which must be completed successfully prior to a CCNs Go-Live Date. DHH may, at its discretion, postpone the Operation Start Date of the Contract for any such CCN that fails to satisfy all Transition Period requirements.

### **Transition Period Requirements**

CCNs must have successfully met all Readiness Review requirements established by DHH no later than 90 days prior to the Go-Live Date. The CCN agrees to provide all materials required to complete the readiness review by the dates established by DHH and/or its Readiness Review contractor.

If a CCN does not fully meet the Readiness Review prior to the Go-Live Date, DHH may impose a monetary penalty for each day beyond the Go-Live Date that the CCN is not operational.

The Transition Period will begin after both Parties sign the Contract. The start date for the CCN Transition Period is anticipated to be September 2011.

The CCN has overall responsibility for the timely and successful completion of each of the Transition Period tasks. The CCN is responsible for clearly specifying and requesting information needed from DHH, other DHH contractors, and Providers in a manner that does not delay the schedule of work to be performed.

### **Contract Start-Up and Planning**

DHH and the CCN will work together during the initial Contract start-up phase to:

- define project management and reporting schedules;
- establish communication protocols between DHH and the CCN;
- establish contacts with DHH contractors;
- establish a schedule for key activities and milestones; and
- clarify expectations for the content and format of Contract Deliverables.

The CCN will be responsible for developing a written work plan, referred to as the Transition/Implementation Plan, which will be used to monitor progress throughout the Transition Period. An updated and detailed Transition/Implementation Plan will be due to DHH within thirty (30) days from the date the contract is signed by the CCN.

### **Administration and Key CCN Personnel**

No later than August 1, 2011, the CCN must designate and identify Key CCN Personnel that meet the requirements of the contract. The CCN will supply DHH with resumes of each Key CCN Personnel as well as organizational information that has changed relative

## CCN-P REQUEST FOR PROPOSALS

to the CCN Proposal, such as updated job descriptions and updated organization charts, (including updated Management Information System (MIS) job descriptions and an updated MIS staff organizational chart), if applicable. If the CCN is using a Subcontractor(s), the CCN must also provide the organization chart for such Subcontractor(s).

No later than the Contract execution date, CCNs must update the information above and provide any additional information as it relates to the Coordinated Care Network program.

### **Financial Readiness Review**

In order to complete a Financial Readiness Review, DHH will require that CCNs update information submitted in their proposal and/or any other requirements specified in the RFPs. This information will include the following and the requirements specified in the Proposal Submission and Evaluation Requirements.

#### **Contractor Identification and Information**

1. The Contractor's legal name, trade name, or any other name under which the Contractor does business, if any.
2. The address and telephone number of the Contractor's headquarters office.
3. A copy of its current Louisiana Department of Insurance Certificate of Authority to provide HMO services.
4. The type of ownership (proprietary, partnership, corporation).
5. The type of incorporation (for profit, not-for-profit, or non-profit) and whether the CCN is publicly or privately owned.
6. If the CCN is an Affiliate or Subsidiary, identify the parent organization.
7. If any changes of ownership of the CCN's company is anticipated during the 12 months following the Proposal due date, the CCN must describe the circumstances of such change and indicate when the change is likely to occur.
8. The name and address of type of support, e.g. guarantees, letters of credit, etc. Indicate if there are maximum limits of the additional financial support.
9. The name and address of any health professional that has at least a five percent financial interest in the CCN and the type of financial interest.
10. The names of officers and directors.
11. The state in which the CCN is incorporated and the state(s) in which the CCN is licensed to do business as an HMO. The CCN must also indicate the state where it is commercially domiciled, if applicable.
12. The CCN's federal taxpayer identification number.

## CCN-P REQUEST FOR PROPOSALS

13. Whether the CCN had a contract terminated or not renewed for non-performance or poor performance within the past five years. In such instance, the CCN must describe the issues and the parties involved, and provide the address and telephone of the principal terminating party. The CCN must also describe any corrective action taken to prevent any future occurrence of the problem leading to the termination.
14. Whether the CCN has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status, and if it has or is, indicate:
  - is current NCQA or URAC accreditation status;
  - if NCQA or URAC accredited, its accreditation term effective dates; and
  - if not accredited, a statement describing whether and when NCQA or URAC accreditation status was ever denied the CCN.

### **Subcontractor Information**

CCN's must submit the following for each proposed Subcontractor, if any:

1. A completed attestation of commitment from each Subcontractor that states the Subcontractor's willingness to enter into a Subcontractor agreement with the CCN and a statement of work for activities to be subcontracted. Attestations must be provided on the Subcontractor's official company letterhead and signed by an official with the authority to bind the company for the subcontracted work.
2. The Subcontractor's legal name, trade name, or any other name under which the Subcontractor does business, if any.
3. The address and telephone number of the Subcontractor's headquarters office
4. The type of ownership (e.g., proprietary, partnership, corporation).
5. The type of incorporation (i.e. for profit, not-for-profit, or non-profit) and whether the Subcontractor is publicly or privately owned.
6. If a Subsidiary or Affiliate, the identification of the parent organization.
7. The name and address of any sponsoring corporation or others who provide financial support to the Subcontractor and type of support, e.g., guarantees, letters of credit, etc. Indicate if there are maximum limits of the additional financial support.
8. The name and address of any health professional that has at least a five percent (5%) financial interest in the Subcontractor and the type of financial interest.
9. The state in which the Subcontractor is incorporated, commercially domiciled, and the state(s) in which the organization is licensed to do business.
10. The Subcontractor's federal taxpayer identification number.

## CCN-P REQUEST FOR PROPOSALS

11. Whether the CCN had a contract terminated or not renewed for non-performance or poor performance within the past five years. In such instance, the CCN must describe the issues and the parties involved, and provide the address and telephone of the principal terminating party. The CCN must also describe any corrective action taken to prevent any future occurrence of the problem leading to the termination.
12. Whether the CCN has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status, and if it has or is, indicate:
  - a. is current NCQA or URAC accreditation status;
  - b. if NCQA or URAC accredited, its accreditation term effective dates; and
  - c. if not accredited, a statement describing whether and when NCQA or URAC accreditation status was ever denied the CCN.

### **Other Information**

1. Briefly describe any regulatory action, sanctions, and/or fines imposed by any federal or Louisiana regulatory entity or a regulatory entity in another state within the last three (3) years, including a description of any letters of deficiencies, corrective actions, findings of non-compliance, and/or sanctions. Please indicate which of these actions or fines, if any, were related to Medicaid or CHIP programs. DHH may, at its option, contact these clients or regulatory agencies and any other individual or organization whether or not identified by the CCN.
2. No later than thirty (30) days after the Contract Effective Date, submit documentation that demonstrates that the CCN has secured the required insurance and bonds in accordance with DHH requirements.
3. Submit annual audited financial statement for fiscal years 2010 and 2011 (2011 to be submitted no later than six months after the close of the fiscal year).
4. Submit an Affiliate Report containing a list of all Affiliates and for DHH's prior review and approval, a schedule of all transactions with Affiliates that, under the provisions of the Contract, will be allowable as expenses in the Financial Report for services provided to the CCN by the Affiliate. Those should include financial terms, a detailed description of the services to provided, and an estimated amount that will be incurred by the CCN for such services during the Contract Period.

### **System Testing and Transfer of Data**

The CCN must have hardware, software, network and communications systems with the capability and capacity to handle and operate all MIS systems and subsystems.

During the Readiness Review task, the CCN will accept into its system any and all necessary data files and information available from DHH or its contractors. The CCN will install and test all hardware, software, and telecommunications required to support the Contract. The CCN will define and test modifications to the CCN's system(s) required to support the business functions of the Contract.

## CCN-P REQUEST FOR PROPOSALS

The CCN will produce data extracts and receive data transfers and transmissions. CCNs must be able to demonstrate the ability to produce encounter file.

If any errors or deficiencies are evident, the CCN will develop resolution procedures to address the problem identified. The CCN will provide DHH, or designated contractor, with test data files for systems and interface testing for all external interfaces. This includes testing of the required telephone lines for Providers and Members and any necessary connections to the Enrollment Broker and External Quality Review Organization. The CCN will demonstrate its system capabilities and adherence to Contract specifications during readiness review.

### **System Readiness Review**

The CCN must assure that system services are not disrupted or interrupted during the Operations Phase of the Contract, as defined in the Information Systems Availability section of the RFP. The CCN must coordinate with DHH and other contractors to ensure the business and systems continuity for the processing of all health care claims and data as required under this Contract.

The CCN must submit to DHH, descriptions of interface and data and process flow for each business processes described in the ***CCN-P Systems Companion Guide***.

The CCN must clearly define and document the policies and procedures that will be followed to support day-to-day systems activities. The CCN must develop, and submit for DHH review and approval, the following information no later than 30 days after the Contract is signed:

1. Disaster Recovery Plan
2. Business Continuity Plan
3. Systems Quality Assurance Plan

### **Demonstration and Assessment of System Readiness**

The CCN must provide documentation on systems and facility security and provide evidence or demonstrate that it is compliant with HIPAA, as specified in the Information Security and Access Management section and as otherwise stated in the RFP. The CCN shall also provide DHH with a summary of all recent external audit reports, including findings and corrective actions, relating to the CCN's proposed systems. The CCN shall promptly make additional information on the detail of such system audits available to DHH upon request.

In addition, DHH will provide to the CCN a test plan that will outline the activities that need to be performed by the CCN prior to the Go-Live Date of the Contract, as outlined in the CCN-P Systems Companion Guide. The CCN must be prepared to assure and demonstrate system readiness. The CCN must execute system readiness test cycles to include all external data interfaces, including those with Subcontractors.

DHH, or its contractors, may independently test whether the CCN's MIS has the capacity to administer a Coordinated Care Network. This Readiness Review of a CCN's MIS may include a desk review and/or an onsite review. Based in part on the CCN's assurances of systems readiness, information contained in the Proposal, additional documentation submitted by the CCN, and any review conducted by DHH or its contractors, DHH will

## CCN-P REQUEST FOR PROPOSALS

assess the CCN's understanding of its responsibilities and the CCN's capability to assume the MIS functions required under the contract.

The CCN is required to provide a Corrective Action Plan in response to any Readiness Review deficiency no later than ten (10) calendar days after notification of any such deficiency by DHH. If the CCN documents to DHH's satisfaction that the deficiency has been corrected within ten (10) calendar days of such deficiency notification by DHH, no Corrective Action Plan is required.

### **Operation Readiness**

The CCN must clearly define and document the policies and procedures that will be followed to support day-to-day business activities related to Louisiana Medicaid enrollees, including coordination with contractors. The CCN will be responsible for developing and documenting its approach to quality assurance.

Readiness Review includes all plans to be implemented in one Geographic Service Area (GSA) on the anticipated Operational Start Date. At a minimum, the CCN shall:

1. Develop operations procedures and associated documentation to support the CCN's proposed approach to conducting operations activities in compliance with the contracted scope of work.
2. Submit to DHH, a listing of all contracted and credentialed Providers, in a DHH approved format including a description of additional contracting and credentialing activities scheduled to be completed before the Go-Live Date.
3. Prepare and implement a Member Services staff training curriculum and a Provider training curriculum.
4. Prepare a Coordination Plan documenting how the CCN will coordinate its business activities with those activities performed by DHH contractors and the CCN's Subcontractors, if any. The Coordination Plan will include identification of coordinated activities and protocols for the Transition Period.
5. Develop and submit to DHH the draft Member Handbook, draft Provider Manual, draft Provider Directory, and draft Member Identification Card for DHH's review and approval. The material must at a minimum meet the requirements specified in the Request for Proposal.
6. Develop and submit to DHH the CCN's proposed Member complaint and appeals processes.
7. Provide sufficient copies of final Provider Directory to the DHH's Enrollment Broker in sufficient time to meet the enrollment schedule.
8. Demonstrate toll-free telephone systems and reporting capabilities for the Member Services Hotline and Provider Service Hotline.

## CCN-P REQUEST FOR PROPOSALS

9. Submit a written Fraud and Abuse Compliance Plan to DHH for approval no later than 30 days from the date the Contract is signed. As part of the Fraud and Abuse Compliance Plan as described in this RFP, the CCN shall:
  - Designate a compliance officer and essential personnel to attend mandatory training in fraud and abuse detection, prevention and reporting. Executive and essential fraud and abuse personnel means CCN staff persons who supervise staff in the following areas: data collection, provider enrollment or disenrollment, encounter data, claims processing, utilization review, appeals or grievances, quality assurance and marketing, and who are directly involved in the decision-making and administration of the fraud and abuse detection program within the CCN.
  - Designate an officer within the organization responsible for carrying out the provisions of the Fraud and Abuse Compliance Plan.
  - The CCN is held to the same requirement and must ensure that, if this function is subcontracted to another entity, the subcontractor also meets all the requirements.

During the Readiness Review, DHH may request from the CCN certain operating procedures and updates to documentation to Coordinated Care Network Services. DHH will assess the CCN's understanding of its responsibilities and the CCN's capability to assume the functions required under the Contract, based in part on the CCN's assurances of operational readiness, information contained in the Proposal, and in Transition Period documentation submitted by the CCN.

The CCN is required to promptly provide a Corrective Action Plan as requested by DHH in response to Operational Readiness Review deficiencies identified by the CCN or by DHH's contractors. The CCN must promptly alert DHH of deficiencies, and must correct a deficiency or provide a Corrective Action Plan no later than ten (10) calendar days after DHH's notification of deficiencies. If the CCN documents to DHH's satisfaction that the deficiency has been corrected within ten (10) calendar days of such deficiency notification by DHH, no Corrective Action Plan is required.

### **Assurance of System and Operation Readiness**

In addition to successfully providing the Deliverables described in the RFP, the CCN must assure DHH that all processes, MIS systems, and staffed functions are ready and able to successfully assume responsibilities for operations prior to the Go-Live Date. In particular, the CCN must assure that Key CCN Personnel, Member Services staff, Provider Services staff, and MIS staff are hired and trained, MIS systems and interfaces are in place and functioning properly, communications procedures are in place, Provider Manuals have been distributed, and that Provider training sessions have occurred according to the schedule approved by DHH.

### **Post-Transition**

The CCN will work with DHH, Providers, and Members to promptly identify and resolve problems identified after the Go-Live Date and to communicate to DHH, Providers, and Members, as applicable, the steps the CCN is taking to resolve the problems.

If a CCN makes assurances to DHH of its readiness to meet Contract requirements, including MIS and operational requirements, but fails to satisfy requirements set forth in this Section, or as otherwise required pursuant to the Contract, DHH may, at its discretion do any of the following in accordance with the severity of the non-compliance and the potential impact on Members and Providers:

1. freeze enrollment into the CCNs plan for the affected GSA;
2. freeze enrollment into the CCNs plan for all affected GSAs;
3. impose contractual monetary penalties; or
4. pursue other equitable, injunctive, or regulatory relief.

## **Appendix KK**

# **CCN-P Proposal Submission and Evaluation Reports**

**CCN-P PROPOSAL EVALUATION POINTS SUMMARY**

**PART I – MANDATORY**

Section	Category	Total Possible Points
A	Mandatory Requirements	0

**PART II – TECHNICAL - Total Possible Points – 1900**

Section	Category	Total Possible Points
B	Qualifications and Experience	345
C	Planned Approach to Project	100
D	Member Enrollment and Disenrollment	25
E	Chronic Care/Disease Management	100
F	Service Coordination	170
G	Provider Network	200
H	Utilization Management	80
I	EPSDT	25
J	Quality Management	125
K	Member Materials	50
L	Customer Service	100
M	Emergency Management Plan	25
N	Grievance and Appeals	25
O	Fraud and Abuse	25
P	Third Party Liability	25
Q	Claims Management	80
R	Information Systems	200
S	Added Value to Louisiana	200
	TOTAL	1900

CCN-P REQUEST FOR PROPOSALS

LOUISIANA COORDINATED CARE NETWORK PROGRAM  
CCN-P PROPOSAL SUBMISSION AND EVALUATION REQUIREMENTS  
RFP # 305PUR-DHHRFP-CCN-P-MVA

PROPOSER NAME

**THE PROPOSER MUST COMPLETE THIS FORM AND SUBMIT WITH THEIR PROPOSAL.**

**PART ONE: MANDATORY REQUIREMENTS**

The Proposer should address ALL Mandatory Requirements section items and should provide, in sequence, the information and documentation as required (referenced with the associated item references).

The DHH Division of Contracts and Procurement Support will review all general mandatory requirements.

The DHH Division of Contracts and Procurement Support will also review the proposal to determine if the Mandatory Requirement Items (below) are met and mark each with included or not included.

Any contract resulting from this RFP process shall incorporate by reference the respective proposal responses to all items below as a part of said Contract (Refer to Section §21 of RFP).

The Proposer should adhere to the specification outlined in Section §21 of the RFP in responding to this RFP. The Proposer should complete all columns marked in **ORANGE ONLY**.

**NOTICE:** In addition to these requirements, DHH will also evaluate compliance with ALL other RFP provisions.

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A,B and/or C)	PART ONE: MANDATORY REQUIREMENT ITEMS	For State Use Only	
			INCLUDED/NOT INCLUDED	DHH COMMENTS
		<p><b>A.1</b> Provide the <b>Proposal Certification Statement (RFP Appendix # A)</b> completed and signed, in the space provided, by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract.</p> <p><i>The Proposer must sign the Proposal Certification Statement without exception or qualification.</i></p>		
		<p><b>A.2</b> Provide a statement signed by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract guaranteeing that there will be no conflict or violation of the Ethics Code if the Proposer is awarded a contract. Ethics issues are interpreted by the Louisiana Board of Ethics.</p>		

## PART II: TECHNICAL PROPOSAL & EVALUATION GUIDE

The Proposer should adhere to the specifications outlined in Section §21 of the RFP in responding to this RFP. The Proposer should address ALL section items and provide, in sequence, the information and documentation as required (referenced with the associated item references and text and complete all columns marked in **ORANGE ONLY**.

\*If the Proposer is proposing to provide services in all GSAs, Proposer may respond by stating “all” in the Specify Applicable GSA Area column. If not, Proposer must specify the specific GSA(s).

Proposal Evaluation Teams, made up of teams of State employees, will evaluate and score the proposal’s responses.

For those items in Part II that state “Included/Not Included” the proposals will be scored as follows:

- a. All items scored Included = 0 points
- b. If 1-3 items are scored “Not Included” = -10 points
- c. If 4-5 items are scored “Not Included” = -20 points
- d. If more than 6 items are scored “Not Included” = -30 points

Any contract resulting from this RFP process shall incorporate by reference the respective proposal responses to all items below as a part of said contract.

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A and/or B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<b>B. Qualifications and Experience (Sections § 2, §3 and §4 of the RFP)</b>	345		
		<p><b>B.1</b> Indicate your organization’s legal name, trade name, <i>dba</i>, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization’s ultimate parent (e.g. publicly traded corporation).</p> <p>Describe your organization’s form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.</p> <p>Provide your federal taxpayer identification number and Louisiana taxpayer identification number.</p> <p>Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provider the name and address of the local representative; if none, so state.</p> <p>If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.</p>	Included/Not Included		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>B.2</b> Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. <b>Include your organization’s parent organization, affiliates, and subsidiaries.</b></p>	<p><b>Included/Not Included</b></p>		
		<p><b>B.3</b> Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled <i>nolo contendere</i> to any felony and/or any Medicaid or health care related offense or have <b>ever</b> been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. <b>Include your organization’s parent organization, affiliates, and subsidiaries.</b></p>	<p><b>0 to -25</b></p>		
		<p><b>B.4</b> Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers’ compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. <b>Include your organization’s parent organization, affiliates, and subsidiaries.</b></p>	<p><b>0 to -25</b></p>		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>B.5</b> Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. <b>Include your organization's parent organization, affiliates, and subsidiaries.</b></p>	0 to -25		
		<p><b>B.6</b> If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report.</p> <p>Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. <b>Include your organization's parent organization, affiliates, and subsidiaries.</b></p>	0 to -25		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>B.7</b> If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.</p> <p>Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.</p>	Included/Not Included		
		<p><b>B.8</b> Describe your organization’s number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. <b>Include your organization’s parent organization, affiliates, and subsidiaries.</b></p>	Included/Not Included		
		<p><b>B.9</b> Provide a narrative description of your proposed Louisiana Medicaid Coordinated Care Network project team, its members, and organizational structure including an organizational chart showing the Louisiana organizational structure, including staffing and functions performed at the local level. If proposing for more than one (1) GSA, include in your description and organizational chart if: 1) the team will be responsible for all GSAs or 2) if each GSA will differ provide details outlining the differences and how it will differ.</p>	15		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>B.10</b> Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience.</p> <p>If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.</p> <p>If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.</p> <p>For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.</p>	40		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>B.11</b> Provide a statement of whether you intend to use major subcontractors (as defined in the RFP Glossary), and if so, the names and mailing addresses of the subcontractors and a description of the scope and portions of the work for each subcontractor with more than \$100,000 annually. Describe how you intend to monitor and evaluate subcontractor performance. Also specify whether the subcontractor is currently providing services for you in other states and where the subcontractor is located.</p> <p>In addition, as part of the response to this item, for each major subcontractor that is not your organization's parent organization, affiliate, or subsidiary, restate and respond to items B.1 through B.7, B10 and, B.16 through B.27</p> <p>If the major subcontractor is your organization's parent organization, affiliate, or subsidiary, respond to items B.1, B.8 and B.9. You do not need to respond to the other items as part of the response to B11; note, however, responses to various other items in Section B must include information on your organization's parent organization, affiliates, and subsidiaries, which would include any major subcontractors that are your organization's parent organization, affiliate, or subsidiary.</p>	10		
		<p><b>B.12</b> Provide a description your Corporate Compliance Program including the Compliance Officer's levels of authority and reporting relationships. Include an organizational chart of staff (marked as Chart B in your response) involved in compliance along with staff levels of authority.</p>	15		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>B.13</b> Provide copies of any press releases in the twelve (12) months prior to the Deadline for Proposals, wherein the press release mentions or discusses financial results, acquisitions, divestitures, new facilities, closures, layoffs, significant contract awards or losses, penalties/fines/ sanctions, expansion, new or departing officers or directors, litigation, change of ownership, or other very similar issues, Do not include press releases that are primarily promotional in nature.</p>	10		
		<p><b>B.14</b> Describe your plan for meeting the Performance Bond, other bonds, and insurance requirements set forth in this RFP requirement including the type of bond to be posted and source of funding.</p>	Included/Not Included		
		<p><b>B.15</b> Provide the following information (in Excel format) based on each of the financial statements provided in response to item B:30: (1) Working capital; (2) Current ratio; (3) Quick ratio; (4) Net worth; and (5) Debt-to-worth ratio.</p>	20		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>B.16</b> Identify, in Excel format, all of your organization’s publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization’s ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer’s ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. <b>Include your organization’s parent organization, affiliates, and subsidiaries.</b></p>	75		
		<p><b>B.17</b> Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. <b>Include your organization’s parent organization, affiliates, and subsidiaries.</b></p>	Included/Not Included		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>B.18</b> If the contract was terminated/non-renewed in B.17 above, based on your organization’s performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. <b>Include your organization’s parent organization, affiliates, and subsidiaries.</b></p>	0 to -25		
		<p><b>B. 19</b> As applicable, provide (in table format) the Proposer’s current ratings as well as ratings for each of the past three years from each of the following:</p> <ul style="list-style-type: none"> <li>• AM Best Company (financial strengths ratings);</li> <li>• TheStreet.com, Inc. (safety ratings); and</li> <li>• Standard &amp; Poor’s (long-term insurer financial strength).</li> </ul>	Included/Not Included		
		<p><b>B.20</b> For any of your organization’s contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer’s control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? <b>Include your organization’s parent organization, affiliates, and subsidiaries.</b></p>	0 to -25		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>B.21</b> Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. If it has or is, indicate current NCQA or URAC accreditation status and accreditation term effective dates if applicable.</p>	<p><b>Included/Not Included</b></p>		
		<p><b>B.22</b> Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. <b>Include your organization's parent organization, affiliates, and subsidiaries.</b></p>	<p><b>0 to -5</b></p>		
		<p><b>B.23</b> If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. <b>Include your organization's parent organization, affiliates, and subsidiaries.</b></p>	<p><b>Included/Not Included</b></p>		
		<p><b>B.24</b> Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (<b>including your organization's parent organization, affiliates, and subsidiaries</b>) in response to the report.</p>	<p><b>25</b></p>		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>B.25</b> Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. <b>Include your organization's parent organization, affiliates, and subsidiaries.</b></p>	<p><b>0 to -50</b></p>		
		<p><b>B.26</b> Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. <b>Include your organization's parent company, affiliates and subsidiaries.</b></p>	<p><b>0 to -25</b></p>		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>B.27</b> Submit client references (minimum of three, maximum of five) for your organization from major subcontractors; with at least one reference from a major subcontractor who have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix PP. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:</p> <ol style="list-style-type: none"> <li>a. Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix PP (for your organization or for subcontractors, adding the following customized information:               <ul style="list-style-type: none"> <li>• Your/Subcontractor’s name;</li> <li>• Geographic Service Area(s) for which the reference is being submitted;</li> <li>• Reference organization’s name; and</li> <li>• Reference contact’s name, title, telephone number, and email address.</li> </ul> </li> <li>b. Send the form to each reference contact along with a new, sealable standard #10 envelope;</li> <li>c. Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal;</li> <li>d. Instruct the reference contact to:               <ul style="list-style-type: none"> <li>• Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission);</li> <li>• Sign and date it;</li> <li>• Seal it in the provided envelope;</li> <li>• Sign the back of the envelope across the seal; and</li> <li>• Return it directly to you.</li> </ul> </li> <li>e. Enclose the unopened envelopes in easily identifiable and labeled larger</li> </ol>	35		

CCN-P REQUEST FOR PROPOSALS

		<p>envelopes and include these envelopes as a part of the Proposal. When DHH the opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references.</p> <p><b>THE STATE WILL NOT ACCEPT LATE REFERENCES OR REFERENCES SUBMITTED THROUGH ANY OTHER CHANNEL OF SUBMISSION OR MEDIUM, WHETHER WRITTEN, ELECTRONIC, VERBAL, OR OTHERWISE.</b></p> <p>Each completed questionnaire should include:</p> <ul style="list-style-type: none"> <li>• Proposing Organization/Subcontractor's name;</li> <li>• GSA (s) for which the reference is being submitted;</li> <li>• Reference Organization's name;</li> <li>• Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work;</li> <li>• Date reference form was completed; and</li> <li>• Responses to numbered items in RFP Attachment # (as applicable).</li> </ul> <p>DHH reserves the authority to clarify information presented in questionnaires and may consider clarifications in the evaluation of references. However DHH is under no obligation to clarify any reference check information.</p>			
		<p><b>B.28</b> Indicate the website address (URL) for the homepage(s) of any website(s) operated, owned, or controlled by your organization, including any that the Proposer has contracted to be run by another entity as well as details of any social media presence ( e.g. Facebook, Twitter). If your organization has a parent, then also provide the same for the parent, and any parent(s) of the parent. If no websites and/or social media presence, so state.</p>	<p><b>Included/Not Included</b></p>		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>B.29</b> Provide evidence that the Proposer has applied to Louisiana Department of Insurance for a certificate of authority (COA) to establish and operate a prepaid entity as defined in RS 22:1016 and in accordance with rules and regulations as defined by the Department of Health and Hospitals.</p>	0 to -25		
		<p><b>B.30</b> Provide the following as documentation of financial responsibility and stability:</p> <ul style="list-style-type: none"> <li>• a current written bank reference, in the form of a letter, indicating that the Proposer’s business relationship with the financial institution is in positive standing;</li> <li>• two current written, positive credit references, in the form of a letters, from vendors with which the Proposer has done business or, documentation of a positive credit rating determined by a accredited credit bureau within the last 6 months;</li> <li>• a copy of a valid certificate of insurance indicating liability insurance in the amount of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in the aggregate; and</li> <li>• a letter of commitment from a financial institution (signed by an authorized agent of the financial institution and detailing the Proposer’s name) for a general line of credit in the amount of five-hundred thousand dollars (\$500,000.00).</li> </ul>	50		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>B.31</b> Provide the following as documentation of the Proposer’s sufficient financial strength and resources to provide the scope of services as required:</p> <ul style="list-style-type: none"> <li>• The two most recent independently audited financial statements and associated enrollment figures from the Proposer. Compiled or reviewed financial statements will not be accepted. The audited financial statements must be: <ul style="list-style-type: none"> <li>○ Prepared with all monetary amounts detailed in U.S. currency;</li> <li>○ Prepared under U.S. generally accepted accounting principles; and</li> <li>○ Audited under U.S. generally accepted auditing standards. The audited financial statements must include the auditor’s opinion letter, financial statements, and the notes to the financial statements.</li> </ul> </li> <li>• The Proposer’s four (4) most recent internally prepared unaudited quarterly financial statements (and Year-to- Date), with preparation dates indicated. The statements must include documentation disclosing the amount of cash flows from operating activities. This documentation must indicate whether the cash flows are positive or negative, and if the cash flows are negative for the quarters, the documentation must include a detailed explanation of the factors contributing to the negative cash flows.</li> <li>• Verification of any contributions made to the Proposer to improve its financial position after its most recent audit (e.g., copies of bank statements and deposit slips), if applicable</li> </ul> <p><b>Proposer shall include the Proposer’s parent organization, affiliates, and subsidiaries.</b></p>	50		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section C: Planned Approach to Project	100		
		<p>Describe how you will launch a network and set up operations capable of supporting its membership and meeting the requirements of the RFP by January 1, 2012 for GSA "A", March 1 of 2012 for GSA "B", and May 1 of 2012 for GSA "C".</p> <p><b>C.1</b> Discuss your approach for meeting the implementation requirements and include:</p> <ul style="list-style-type: none"> <li>• A detailed description of your project management methodology. The methodology should address, at a minimum, the following:               <ul style="list-style-type: none"> <li>○ Issue identification, assessment, alternatives analysis and resolution;</li> <li>○ Resource allocation and deployment;</li> <li>○ Reporting of status and other regular communications with DHH, including a description of your proposed method for ensuring adequate and timely reporting of information to DHH project personnel and executive management; and</li> <li>○ Automated tools, including use of specific software applications.</li> </ul> </li> </ul>	20		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>C.2</b> Provide a work plan for the implementation of the Louisiana Medicaid CCN Program. At a minimum the work plan should include the following:</p> <ul style="list-style-type: none"> <li>• Tasks associated with your establishment of a “project office” or similar organization by which you will manage the implementation of the CCN Program;</li> <li>• An itemization of activities that you will undertake during the period between the awarding of this procurement and the start date of the CCN Program. These activities shall have established deadlines and timeframes and as needed conform to the timelines established under this RFP for deliverables. <ul style="list-style-type: none"> <li>○ All activities to prepare for and participate in the Readiness Review Process; and</li> <li>○ All activities necessary to obtain required contracts for mandatory health care providers as specified in this RFP.</li> </ul> </li> <li>• An estimate of person-hours associated with each activity in the Work Plan;</li> <li>• Identification of interdependencies between activities in the Work Plan; and</li> <li>• Identification of your expectations regarding participation by DHH and/or its agents in the activities in the Work Plan and dependencies between these activities and implementation activities for which DHH will be responsible. (In responding the CCN shall understand DHH shall not be obligated to meet the CCN’s expectation.)</li> </ul>	<b>25</b>		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>C.3</b> Describe your Risk Management Plan.</p> <ul style="list-style-type: none"> <li>• At a minimum address the following contingency scenarios that could be encountered during implementation of the program:                             <ul style="list-style-type: none"> <li>o Delays in building the appropriate Provider Network as stipulated in this RFP;</li> <li>o Delays in building and/or configuring and testing the information systems within your organization’s Span of Control required to implement the CCN program;</li> <li>o Delays in hiring and training of the staff required to operate program functions;</li> <li>o Delays in the construction and/or acquisition of office space and the delivery of office equipment for staff required to operate program functions;</li> <li>o Delays in enrollment processing during the implementation of CCN; and</li> <li>o Delays in the publication of marketing and related materials and/or the delivery of these materials to DHH and/or its agents.</li> </ul> </li> <li>• For each contingency scenario identified in the Proposal, at a minimum the Risk Management Plan must include the following:                             <ul style="list-style-type: none"> <li>o Risk identification and mitigation strategies;</li> <li>o Risk management implementation plans; and</li> <li>o Proposed or recommended monitoring and tracking tools.</li> </ul> </li> </ul>	25		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>C.4</b> Provide a copy of the Work Plan, generated in Microsoft Project or similar software product that includes the aforementioned implementation activities along with the timeframes, person-hours, and dependencies associated with these activities.</p>	20		
		<p><b>C.5</b> Provide a roster of the members of the proposed implementation team including the group that will be responsible for finalizing the Provider network.</p>	5		
		<p><b>C.6</b> Provide the resume of the Implementation Manager (the primary person responsible for coordinating implementation activities and for allocating implementation team resources).</p>	5		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section D: Member Enrollment and Disenrollment	25		
		D.1 Describe your enrollment procedure requirements, including how you will ensure that you will coordinate with DHH and its Agent.	5		
		D.2 Describe your approach to meeting the newborn enrollment requirements, including how you will: <ul style="list-style-type: none"> <li>• Encourage Members who are expectant mothers to select a CCN and PCP for their newborns; and</li> <li>• Ensure that newborn notification information is submitted, either by you or the hospital, to DHH or its Agent within twenty-four (24) hours of the birth of the newborn.</li> </ul>	5		
		D.3 Describe the types of interventions you will use prior to seeking to disenroll a Member as described in CCN Initiated Member Disenrollment, <b>Section § 11</b> of this RFP. If applicable, provide an example of a case in which you have successfully intervened to avert requesting the disenrollment of a member.	10		
		D.4 Describe the steps you will take to assign a member to a different Provider in the event a PCP requests the Member be assigned elsewhere.	5		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section E: Chronic Care/Disease Management (Section § 6 of RFP)	100		
		E.1 Describe existing (other state Medicaid or CHIP contracts) and planned Chronic Care/Disease Management programs for the Louisiana CCN Program that are designed to improve health care outcomes for members with one or more chronic illnesses. Describe how the Chronic Care/Disease Management programs' data are analyzed and the results utilized by your organization to improve member outcomes.	50		
		E.2 Describe how recipients will be identified for inclusion into the Chronic Care/Disease Management program. Identify which disease states/ recipient types will be targeted for the Chronic Care/Disease Management program. Describe how the Chronic Care/Disease Management program will coordinate information and services with the PCP.	50		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<b>Section F: Service Coordination (Section § 14 of RFP)</b>	<b>170</b>		
		<p><b>F.1</b> DHH intends to provide CCNs with two years of historic claims data for members enrolled in the CCN effective the start date of operations. Describe how you will ensure the continuation of medically necessary services for members with special health needs who are enrolled in your CCN effective the start date of operations. The description should include:</p> <ul style="list-style-type: none"> <li>• How you will identify these enrollees, and how you will uses this information to identify these enrollees, including enrollees who are receiving regular ongoing services;</li> <li>• What additional information you will request from DHH, if any, to assist you in ensuring continuation of services;</li> <li>• How you will ensure continuation of services, including prior authorization requirements, use of non-contract providers, and transportation;</li> <li>• What information, education, and training you will provide to your providers to ensure continuation of services; and</li> <li>• What information you will provide your members to assist with the transition of care.</li> </ul>	<b>10</b>		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>F.2</b> Describe your approach to CCN case management. In particular, describe the following:</p> <ul style="list-style-type: none"> <li>• Characteristics of members that you will target for CCN case management services;</li> <li>• How you identify these members;</li> <li>• How you encourage member participation;</li> <li>• How you assess member needs;</li> <li>• How you develop and implement individualized plans of care, including coordination with providers and support services;</li> <li>• How you coordinate your disease management and CCN case management programs;</li> <li>• How you will coordinate your case management services with the PCP; and</li> <li>• How you will incorporate provider input into strategies to influence behavior of members.</li> </ul>	<b>85</b>		
		<p><b>F.3</b> Describe your approach for coordinating the following carved out services which will continue to be provided by the Medicaid fee-for-service program:</p> <ul style="list-style-type: none"> <li>• Dental</li> <li>• Specialized Behavioral Health</li> <li>• Personal Care Services</li> <li>• Targeted Case Management</li> </ul>	<b>5</b>		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>F.4</b> For members who need home health services upon discharge from an acute care hospital, explain how you will coordinate service planning and delivery among the hospital’s discharge planner(s), your case manager(s), your disease management staff member(s), and the home health agency. Further, explain how you will monitor the post-discharge care of enrollees receiving home health services in remote areas.</p>	10		
		<p><b>F.5</b> Aside from transportation, what specific measures will you take to ensure that members in rural parishes are able to access specialty care? Also address specifically how will you ensure members with disabilities have access?</p>	10		
		<p><b>F.6</b> Detail the strategies you will use to influence the behavior of members to access health care resources appropriately and adapt healthier lifestyles. Include examples from your other Medicaid/CHIP managed care contracts as well as your plan for Louisiana Medicaid CCN members.</p>	40		
		<p><b>F.7</b> Many faith based, social and civic groups, resident associations, and other community-based organizations now feature health education and outreach activities, incorporate health education in their events, and provide direct medical services (e.g., through visiting nurses, etc.). Describe what specific ways would you leverage these resources to support the health and wellness of your members.</p>	10		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>F.8</b> Submit a statement of any moral and religious objections to providing any services covered under Section §6 of RFP. If moral and religious objections are identified describe, in as much detail as possible, all direct and related services that are objectionable. Provide a listing of the codes impacted including but not limited to CPT codes, HCPCS codes, diagnosis codes, revenue codes, modifier codes, etc. If none, so state. Describe your plans to provide these services (e.g. birth control) to members who are entitled to such services.</p>	<p><b>Included/Not Included</b></p>		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section G: Provider Network (Section § 7 of RFP)	200		
		<p><b>G.1</b> Provide a listing of the proposed provider network using the List of Required In-Network and Allowable Out-of-Network Providers as described in this RFP, including only those providers with whom you have obtained a signed LOI or executed subcontract. LOIs and signed subcontracts will receive equal consideration. LOIs and subcontracts should NOT be submitted with the proposal. DHH may verify any or all referenced LOIs or contracts. Along with the provider listing, provide the number of potential linkages per PCP.</p> <p>Using providers with whom you have signed letters of intent or executed contracts, provide individual GeoAccess maps and coding by GSA for: 1) hospitals, 2) primary care providers, FQHCs, and RHCs; and 3) Specialists. You should provide individual maps as well as overlay maps to demonstrate distance relationships between provider types.</p>	50		
		<p><b>G.2</b> Describe how you will provide tertiary care providers including trauma centers, burn centers, children’s hospital, Level III maternity care; Level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day in the GSA. If you do not have a full range of tertiary care providers describe how the services will be provided including transfer protocols and arrangements with out of network facilities.</p>	15		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>G.3</b> Describe how you will handle the potential loss (i.e., contract termination, closure) in a GSA of a) a hospital and b) all providers within a certain specialty.</p>	10		
		<p><b>G.4</b> The CCN is encouraged to offer to contract with Significant Traditional Providers (STPs) who meet your credentialing standards and all the requirements in the CCN’s subcontract. DHH will make available on <a href="http://www.MakingMedicaidBetter.com">www.MakingMedicaidBetter.com</a> a listing of STPs by provider type by GSA. Describe how you will encourage the enrollment of STPs into your network; and indicate on a copy of the listing which of the providers included in your listing of network providers (See G.3) are STPs.</p>	20		
		<p><b>G.5</b> Based on discussions with providers in obtaining Letters of Intent and executed subcontracts as well as other activities you have undertaken to understand the delivery system and enrollee population in the GSA(s) for which a proposal is being submitted, discuss your observations and the challenges you have identified in terms of developing and maintaining a provider network. Provide a response tailored to each GSA of the following provider types/services:</p> <ul style="list-style-type: none"> <li>o Primary Care</li> <li>o Specialty Care</li> <li>o Prenatal Care Services</li> <li>o Hospital, including Rural Hospital</li> <li>o Office of Public Health</li> <li>o Private Duty Nursing/Home Health Services;</li> <li>o FQHC</li> <li>o School Based Health Clinic</li> </ul>	5		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<b>G.6</b> Describe your process for monitoring and ensuring adherence to DHH's requirements regarding appointments and wait times.	20		
		<b>G.7</b> Describe your PCP assignment process and the measures taken to ensure that every member in your CCN is assigned a PCP in a timely manner. Include your process for permitting members with chronic conditions to select a specialist as their PCP and whether you allow specialists to be credentialed to act as PCPs.	10		
		<b>G.8</b> Describe your plan for working with PCPs to obtain NCQA medical home recognition or JHCAO Primary Home accreditation and meeting the requirements of Section § 14.	5		
		<b>G.9</b> Describe how you will monitor providers and ensure compliance with provider subcontracts. In addition to a general description of your approach, address each of the following: <ul style="list-style-type: none"> <li>o Compliance with cost sharing requirements;</li> <li>o Compliance with medical record documentation standards;</li> <li>o Compliance with conflict of interest requirements;</li> <li>o Compliance with lobbying requirements;</li> <li>o Compliance with disclosure requirements; and</li> <li>o Compliance with marketing requirements.</li> </ul>	5		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>G.10</b> Provide an example from your previous experience of how you have handled provider noncompliance with contract requirements.</p>	5		
		<p><b>G.11</b> Describe in detail how you will educate and train providers about billing requirements, including both initial education and training prior to the start date of operations and ongoing education and training for current and new providers.</p>	10		
		<p><b>G.12</b> Describe how you will educate and train providers that join your network after program implementation. Identify the key requirements that will be addressed.</p>	15		
		<p><b>G.13</b> Describe your practice of profiling the quality of care delivered by network PCPs, and any other acute care providers (e.g., high volume specialists, hospitals), including the methodology for determining which and how many Providers will be profiled.</p> <ul style="list-style-type: none"> <li>○ Submit sample quality profile reports used by you, or proposed for future use (identify which).</li> <li>○ Describe the rationale for selecting the performance measures presented in the sample profile reports.</li> <li>○ Describe the proposed frequency with which you will distribute such reports to network providers, and identify which providers will receive such profile reports.</li> </ul>	15		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>G.14</b> Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the provider grievance and appeal process.</p>	10		
		<p><b>G.1</b> Describe in detail your proposed approach to providing non-emergency medical transportation (NEMT) services, including, at a minimum:</p> <ul style="list-style-type: none"> <li>• What administrative functions, if any, you will subcontract to another entity;</li> <li>• How you will determine the appropriate mode of transportation (other than fixed route) for a member;</li> <li>• Your proposed approach to covering fixed route transportation;</li> <li>• How you will ensure that pick-up and delivery standards are met by NEMT providers, including training, monitoring, and sanctions;</li> <li>• How you will ensure that vehicles (initially and on an ongoing basis) meet vehicle standards, including inspections and other monitoring;</li> <li>• Your approach to initial and ongoing driver training;</li> <li>• How you will ensure that drivers meet initial and ongoing driver standards;</li> <li>• How your call center will comply with the requirements specific to NEMT calls; and</li> <li>• Your NEMT quality assurance program (excluding vehicle inspection).</li> </ul>	5		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<b>Section H: Utilization Management (UM) (Section § 8 of RFP)</b>	<b>80</b>		
		<b>H.1</b> Describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan.	<b>30</b>		
		<b>H.2</b> If the UM guidelines were developed internally, describe the process by which they were developed and when they were developed or last revised.	<b>10</b>		
		<b>H.3</b> Regarding your utilization management (UM) staff: <ul style="list-style-type: none"> <li>• Provide a detailed description of the training you provide your UM staff;</li> <li>• Describe any differences between your UM phone line and your member services line with respect to bullets (2) through (7) in item L.1;</li> <li>• If your UM phone line will handle both Louisiana CCN and non-Louisiana CCN calls,               <ul style="list-style-type: none"> <li>○ explain how you will track CCN calls separately; and</li> <li>○ how you will ensure that applicable DHH timeframes for prior authorization decisions are met.</li> </ul> </li> </ul>	<b>20</b>		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>H.4</b> Describe how utilization data is gathered, analyzed, and reported. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider and a member. Provide an example of how your analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system.</p>	<p><b>20</b></p>		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<b>Section I: EPSDT(Section § 6 of RFP)</b>	<b>25</b>		
		<p><b>I.1</b> Describe your system for tracking each member’s screening, diagnosis, and treatment including, at minimum, the components of the system, the key features of each component, the use of technology, and the data sources for populating the system.</p>	<b>5</b>		
		<p><b>I.2</b> Describe your approach to member education and outreach regarding EPSDT including the use of the tracking system described in I.1 above and any innovative/non-traditional mechanisms. Include:</p> <ul style="list-style-type: none"> <li>• How you will conduct member education and outreach regarding EPSDT including any innovative/non-traditional methods that go beyond the standard methods;</li> <li>• How you will work with members to improve compliance with the periodicity schedule, including how you will motivate parents/members and what steps you will take to identify and reach out to members (or their parents) who have missed screening appointments (highlighting any innovative/non-traditional approaches); and</li> </ul> <p>How you will design and monitor your education and outreach program to ensure compliance with the RFP.</p>	<b>10</b>		
		<p><b>I.3</b> Describe your approach to ensuring that providers deliver and document all required components of EPSDT screening.</p>	<b>5</b>		
		<p><b>I.4</b> Describe how you will ensure that needs identified in a screening are met with timely and appropriate services.</p>	<b>5</b>		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<b>Section J: Quality Management (Section 14 of RFP)</b>	<b>125</b>		
		<p><b>J.1</b> Document experience in other States to positively impact the healthcare status of Medicaid and or CHIP populations. Examples of areas of interest include, but are not limited to the following:</p> <ul style="list-style-type: none"> <li>• Management of high risk pregnancy</li> <li>• Reductions in low birth weight babies</li> <li>• Pediatric Obesity (children under the age of 19)</li> <li>• Reduction of inappropriate utilization of emergent services</li> <li>• EPSDT</li> <li>• Children with special health care needs</li> <li>• Asthma</li> <li>• Diabetes</li> <li>• Cardiovascular diseases</li> <li>• Case management</li> <li>• Reduction in racial and ethnic health care disparities to improve health status</li> <li>• Hospital readmissions and avoidable hospitalizations</li> </ul>	<b>30</b>		
		<p><b>J.2</b> Describe the policies and procedures you have in place to reduce health care associated infection, medical errors, preventable serious adverse events (never events) and unnecessary and ineffective performance in these areas.</p>	<b>10</b>		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>J.3</b> Describe how you will identify quality improvement opportunities. Describe the process that will be utilized to select a performance improvement project, and the process to be utilized to improve care or services. Include information on how interventions will be evaluated for effectiveness. Identify proposed members of the Quality Assessment Committee.</p>	15		
		<p><b>J.4</b> Provide a description of focus studies performed, quality improvement projects, and any improvements you have implemented and their outcomes. Such outcomes should include cost savings realized, process efficiencies, and improvements to member health status. Such descriptions should address such activities since 2001 and how issues and root causes were identified, and what was changed.</p>	15		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>J.5</b> Describe your proposed Quality Assessment and Improvement Program (QAIP). Such description should address:</p> <ul style="list-style-type: none"> <li>• The QAIPs proposed to be implemented during the term of the contract.</li> <li>• How the proposed QAIP s will expand quality improvement services.</li> <li>• How the proposed QAIP will improve the health care status of the Louisiana Medicaid population.</li> <li>• Rationale for selecting the particular programs including the identification of particular health care problems and issues identified within the Louisiana Medicaid population that each program will address and the underlying cause(s) of such problems and issues.</li> <li>• How your will keep DHH informed of QAPI program actions, recommendations and outcomes on an ongoing and timely manner.</li> <li>• How the proposed QAIPs may include, but is not necessarily, limited to the following:               <ul style="list-style-type: none"> <li>○ New innovative programs and processes.</li> <li>○ Contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts and/or School Based Health Clinics.</li> </ul> </li> </ul>	<b>20</b>		
		<p><b>J.6</b> Describe how feedback (complaints, survey results etc.) from members and providers will be used to drive changes and/or improvements to your operations. Provide a member and a provider example of how feedback has been used by you to drive change in other Medicaid managed care contracts.</p>	<b>10</b>		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p>J.7 Provide, in Excel format, the Proposer’s results for the HEDIS measures specified below for the last three measurement years (2007, 2008, and 2009) for each of your State Medicaid contracts.</p> <ul style="list-style-type: none"> <li>• If you do not have results for a particular measure or year, provide the results that you do have.</li> <li>• If you do not have results for your Medicaid product line in a state where you have a Medicaid contract, provide the commercial product line results with an indicator stating the product line.</li> <li>• If you do not have Medicaid HEDIS results for at least five states, provide your commercial HEDIS measures for your largest contracts for up to five states (e.g., if you have HEDIS results for the three states where you have a Medicaid contract, you only have Medicare HEDIS for one other state, provide commercial HEDIS results for another state).</li> <li>• If you do not have HEDIS results for five states, provide the results that you do have.</li> <li>• In addition to the spreadsheet, please provide an explanation of how you selected the states, contracts, product lines, etc. that are included in the spreadsheet and explain any missing information (measure, year, or Medicaid contract). Include the Proposer’s parent organization, affiliates, and subsidiaries.</li> </ul>	25		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p>Provide results for the following HEDIS measures:</p> <ul style="list-style-type: none"> <li>• Adults' Access to Preventive/Ambulatory Health Services</li> <li>• Comprehensive Diabetes Care- HgbA1C component</li> <li>• Chlamydia Screening in Women</li> <li>• Well-Child Visits in the 3,4,5,6 years of life</li> <li>• Adolescent well-Care.</li> <li>• Ambulatory Care - ER utilization</li> <li>• Childhood Immunization status</li> <li>• Breast Cancer Screening</li> <li>• Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care)</li> <li>• Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents</li> </ul> <p><b>. Include the Proposer's parent organization, affiliates, and subsidiaries</b></p>			

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<b>Section K: Member Materials (Section § 12 of RFP)</b>	<b>50</b>		
		<b>K.1</b> Describe proposed content for your member educational materials) and attach a examples used with Medicaid or CHIP populations in other states.	<b>15</b>		
		<b>K.2</b> Describe how you will ensure that all written materials meet the language requirements and which reference material you anticipate you will use to meet the sixth (6 <sup>th</sup> ) grade reading level requirement.	<b>5</b>		
		<b>K.3</b> Describe your process for producing Member ID cards and information that will accompany the card. Include a layout of the card front and back. Explain how you will ensure that a Member receives a new Member ID Card whenever there has been a change in any of the information appearing on the Member ID Card.	<b>10</b>		
		<b>K.4</b> Describe your strategy for ensuring the information in your provider directory is accurate and up to date, including the types and frequency of monitoring activities and how often the directory is updated.	<b>10</b>		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>K.5</b> Describe how you will fulfill Internet presence and Web site requirements, including:</p> <ul style="list-style-type: none"> <li>• Your procedures for up-dating information on the Web site;</li> <li>• Your procedures for monitoring e-mail inquiries and providing accurate and timely responses; and</li> <li>• The procedures, tools and reports you will use to track all interactions and transactions conducted via the Web site activity including the timeliness of response and resolution of said interaction/transaction.</li> </ul>	10		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<b>Section L: Customer Service (Section §12 of RFP)</b>	<b>100</b>		
		<p><b>L.1</b> Provide a narrative with details regarding your member services line including:</p> <ul style="list-style-type: none"> <li>○ Training of customer service staff (both initial and ongoing);</li> <li>○ Process for routing calls to appropriate persons, including escalation; (3) The type of information that is available to customer service staff and how this is provided (e.g., hard copy at the person’s desk or on-line search capacity);</li> <li>○ Process for handling calls from members with Limited English Proficiency and persons who are hearing impaired;</li> <li>○ Monitoring process for ensuring the quality and accuracy of information provided to members;</li> <li>○ Monitoring process for ensuring adherence to performance standards;</li> <li>○ How your customer service line will interact with other customer service lines maintained by state, parish, or city organizations (e.g Partners for Healthy Babies, WIC, housing assistance, and homeless shelters); and</li> <li>○ After hours procedures.</li> </ul>	<b>25</b>		
		<p><b>L.2</b> Provide member hotline telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as of January 1, 2011 for the most recent four (4) quarters, with data that show the monthly call volume, the trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system) and the monthly trends for the rate.</p>	<b>25</b>		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>L.3</b> Describe the procedures a Member Services representative will follow to respond to the following situations:</p> <ul style="list-style-type: none"> <li>○ A member has received a bill for payment of covered services from a network provider or out-of-network provider;</li> <li>○ A member is unable to reach her PCP after normal business hours;</li> <li>○ A Member is having difficulty scheduling an appointment for preventive care with her PCP; and</li> <li>○ A Member becomes ill while traveling outside of the GSA.</li> </ul>	<b>20</b>		
		<p><b>L.4</b> Describe how you will ensure culturally competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.</p>	<b>15</b>		
		<p><b>L.5</b> Describe how you will ensure that covered services are provided in an appropriate manner to members with Limited English proficiency and members who are hearing impaired, including the provision of interpreter services.</p>	<b>15</b>		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section M: Emergency Management Plan (Section § 2 of RFP)	25		
		<p><b>M.1</b> Describe your emergency response continuity of operations plan. Attach a copy of your plan or, at a minimum, summarize how your plan addresses the following aspects of pandemic preparedness and natural disaster recovery:</p> <ul style="list-style-type: none"> <li>○ Employee training;</li> <li>○ Identified essential business functions and key employees within your organization necessary to carry them out; Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;</li> <li>○ Communication with staff and suppliers when normal systems are unavailable;</li> <li>○ Specifically address your plans to ensure continuity of services to providers and members; and</li> <li>○ How your plan will be tested.</li> </ul>	15		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>M.2</b> Describe your plan in the following Emergency Management Plan scenario for being responsive to DHH, to members who evacuate, to network providers, and to the community.</p> <ul style="list-style-type: none"> <li>You have thirty thousand (50,000) or more CCN members residing in hurricane prone parishes. All three GSAs include coastal parish and inland parishes subject to mandatory evacuation orders during a major hurricane. A category 5 hurricane is approaching, with landfall predicted in 72 hours and parishes within the GSA are under a mandatory evacuation order. State assisted evacuations and self evacuations are underway. Members are evacuated to or have evacuated themselves to not only all other areas of Louisiana, but to other States.</li> <li>Your provider call center and member call center are both located in Baton Rouge and there is a high likelihood of high winds, major damage and power outages for 4 days or more in the Baton Rouge Area (reference Hurricane Gustav impact on Baton Rouge). It is expected that repatriation of the evacuated, should damages be minimal, will not occur for 14 days. If damage is extensive, there may be limited repatriation, while other members may be indefinitely relocated to other areas in Louisiana or other states.</li> </ul>	10		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section N: Grievances and Appeals (Section § 13 of RFP )	25		
		<p><b>N.1</b> Provide a flowchart (marked as Chart C) and comprehensive written description of your member grievance and appeals process, including your approach for meeting the general requirements and plan to:</p> <ul style="list-style-type: none"> <li>o Ensure that the Grievance and Appeals System policies and procedures, and all notices will be available in the Member’s primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal;</li> <li>o Ensure that individuals who make decisions on Grievances and Appeals have the appropriate expertise and were not involved in any previous level of review; and</li> <li>o Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member’s health. As part of this process, explain how you will determine when the expedited process is necessary.</li> </ul> <p>Include in the description how data resulting from the grievance system will be used to improve your operational performance.</p>	25		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<b>Section O: Fraud &amp; Abuse (Section § 15 of RFP)</b>	<b>25</b>		
		<b>O.1</b> Describe your approach for meeting the program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Discuss your approach for meeting the coordination with DHH and other agencies requirement.	<b>25</b>		
		<b>Section P: Third Party Liability (Section § 5 of RFP)</b>	<b>25</b>		
		<b>P.1</b> Describe how you will coordinate with DHH and comply with the requirements for cost avoidance and the collection of third party liability (TPL), including: <ul style="list-style-type: none"> <li>o How you will conduct diagnosis and trauma edits, including frequency and follow-up action to determine if third party liability exists; (2) How you will educate providers to maximize cost avoidance;</li> <li>o Collection process for pay and chase activity and how it will be accomplished;</li> <li>o How subrogation activities will be conducted;</li> <li>o How you handle coordination of benefits in your current operations and how you would adapt your</li> <li>o Whether you will use a subcontractor and if so, the subcontractor's responsibilities; and</li> <li>o What routine systems/business processes are employed to test, update and validate enrollment and TPL data.</li> </ul>	<b>25</b>		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	<b>PART II: TECHNICAL APPROACH</b>	Total Possible Points	Score	DHH Comments
		<b>Section Q: Claims Management (Section § 17 of RFP)</b>	<b>80</b>		
		<p><b>Q.1</b> Describe the capabilities of your claims management systems as it relates to each of the requirements as specified in Electronic Claims Management Functionality Section and the Adherence to Key Claims Management Standards Section. In your response explain whether and how your systems meet (or exceed) each of these requirements. Cite at least three examples from similar contracts.</p>	<b>30</b>		
		<p><b>Q.2</b> Describe your methodology for ensuring that claims payment accuracy standards will be achieved per, Adherence to Key Claims Management Standards Section. At a minimum address the following in your response:</p> <ul style="list-style-type: none"> <li>• The process for auditing a sample of claims as described in Key Claims Management Standards Section;</li> <li>• The sampling methodology itself;</li> <li>• Documentation of the results of these audits; and</li> <li>• The processes for implementing any necessary corrective actions resulting from an audit.</li> </ul>	<b>25</b>		
		<p><b>Q.3</b> Describe your methodology for ensuring that the claims processing, including adherence to all service authorization procedures, are met.</p>	<b>25</b>		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section R: Information Systems (Section § 16 of RFP)	200		
		<p>R.1 Describe your approach for implementing information systems in support of this RFP, including:</p> <ul style="list-style-type: none"> <li>• Capability and capacity assessment to determine if new or upgraded systems, enhanced systems functionality and/or additional systems capacity are required to meet contract requirements;</li> <li>• Configuration of systems (e.g., business rules, valid values for critical data, data exchanges/interfaces) to accommodate contract requirements;</li> <li>• System setup for intake, processing and acceptance of one-time data feeds from the State and other sources, e.g., initial set of CCN enrollees, claims/service utilization history for the initial set of CCN enrollees, active/open service authorizations for the initial set CCN enrollees, etc.; and</li> <li>• Internal and joint (CCN and DHH) testing of one-time and ongoing exchanges of eligibility/enrollment, provider network, claims/encounters and other data.</li> <li>• Provide a Louisiana Medicaid CCN-Program-specific work plan that captures: <ul style="list-style-type: none"> <li>○ Key activities and timeframes and</li> <li>○ Projected resource requirements from your organization for implementing information systems in support of this contract.</li> </ul> </li> <li>• Describe your historical data process including but not limited to: <ul style="list-style-type: none"> <li>○ Number of years retained;</li> </ul> </li> </ul>	25		

CCN-P REQUEST FOR PROPOSALS

	<ul style="list-style-type: none"> <li>o How the data is stored; and</li> <li>o How accessible is it.</li> </ul> <p>The work plan should cover activities from contract award to the start date of operations.</p>			
	<p><b>R.2</b> Describe your processes, including procedural and systems-based internal controls, for ensuring the integrity, validity and completeness of all information you provide to DHH and the Enrollment Broker. In your description, address separately the encounter data-specific requirements <b>in, Encounter</b> Data Section of the RFP as well as how you will reconcile encounter data to payments according to your payment cycle, including but not limited to reconciliation of gross and net amounts and handing of payment adjustments, denials and pend processes. Additionally, describe how you will accommodate DHH-initiated data integrity, validity and provide independent completeness audits.</p>	15		
	<p><b>R.3</b> Describe in detail how your organization will ensure that the availability of its systems will, at a minimum, be equal to the standards set forth in the RFP. At a minimum your description should encompass: information and telecommunications systems architecture; business continuity/disaster recovery strategies; availability and/or recovery time objectives by major system; monitoring tools and resources; continuous testing of all applicable system functions, and periodic and ad-hoc testing of your business continuity/disaster recovery plan.</p> <p>Identify the timing of implementation of the mix of technologies and management strategies (policies and procedures) described in your response to (a), or indicate whether these technologies and management strategies are already in place.</p> <p>Elaborate, if applicable, on how you have successfully implemented the aforementioned mix of technologies and management strategies with other clients.</p>	15		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>R.4</b> Describe in detail:</p> <ul style="list-style-type: none"> <li>• How your <i>key production systems</i> are designed to <i>interoperate</i>. In your response address all of the following:               <ul style="list-style-type: none"> <li>○ How identical or closely related data elements in different systems are named, formatted and maintained:                   <ul style="list-style-type: none"> <li>- Are the data elements named consistently;</li> <li>- Are the data elements formatted similarly (# of characters, type-text, numeric, etc.);</li> <li>- Are the data elements updated/refreshed with the same frequency or in similar cycles; and</li> <li>- Are the data elements updated/refreshed in the same manner (manual input, data exchange, automated function, etc.).</li> </ul> </li> <li>○ All exchanges of data between key production systems.                   <ul style="list-style-type: none"> <li>- How each data exchange is triggered: a manually initiated process, an automated process, etc.</li> <li>- The frequency/periodicity of each data exchange: “real-time” (through a live point to-point interface or an interface “engine”), daily/nightly as triggered by a system processing job, biweekly, monthly, etc.</li> </ul> </li> </ul> </li> <li>• As part of your response, provide diagrams that illustrate:               <ul style="list-style-type: none"> <li>○ point-to-point interfaces,</li> <li>○ information flows,</li> <li>○ internal controls and</li> <li>○ the networking arrangement (AKA “network diagram”) associated with the information systems profiled.</li> </ul> </li> </ul> <p>These diagrams should provide insight into how your Systems will be organized and interact with DHH systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with the Louisiana Medicaid CCN Program.</p>	15		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>R.5</b> Describe your ability to provide and store encounter data in accordance with the requirements in this RFP. In your response:</p> <ul style="list-style-type: none"> <li>• Explain whether and how your systems meet (or exceed) each of these requirements.</li> <li>• Cite at least three currently-live instances where you are successfully providing encounter data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications, with at least two of these instances involving the provision of encounter information from providers with whom you have capitation arrangements. In elaborating on these instances, address all of the requirements in Section 17. Also, explain how that experience will apply to the Louisiana Medicaid CCN Program.</li> <li>• If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement. (4) Identify challenges and “lessons learned” from your implementation and operations experience in other states and describe how you will apply these lessons to this contract.</li> </ul>	15		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>R.6</b> Describe your ability to receive, process, and update eligibility/enrollment, provider data, and encounter data to and from the Department and its agents. In your response:</p> <ul style="list-style-type: none"> <li>• Explain whether and how your systems meet (or exceed) each of these requirements.</li> <li>• Cite at least three currently-live instances where you are successfully receiving, processing and updating eligibility/enrollment data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications. In elaborating on these instances, address all of the requirements in Section 17. Also, explain how that experience will apply to the Louisiana Medicaid CCN Program.</li> <li>• If you are not able at present to meet a particular requirement contained in the aforementioned sections, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.</li> <li>• Identify challenges and “lessons learned” from implementation in other states and describe how you will apply these lessons to this contract.</li> </ul>	15		
		<p><b>R.7</b> Describe the ability within your systems to meet (or exceed) each of the requirements in Section §16. Address each requirement. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.</p>	15		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>R.8</b> Describe your information systems change management and version control processes. In your description address your production control operations.</p>	10		
		<p><b>R.9</b> Describe your approach to demonstrating the readiness of your information systems to DHH prior to the start date of operations. At a minimum your description must address:</p> <ul style="list-style-type: none"> <li>• provider contract loads and associated business rules;</li> <li>• eligibility/enrollment data loads and associated business rules;</li> <li>• claims processing and adjudication logic; and</li> <li>• encounter generation and validation prior to submission to DHH.</li> </ul>	15		
		<p><b>R.10</b> Describe your reporting and data analytic capabilities including:</p> <ul style="list-style-type: none"> <li>• generation and provision to the State of the management reports prescribed in the RFP;</li> <li>• generation and provision to the State of reports on request;</li> <li>• the ability in a secure, inquiry-only environment for authorized DHH staff to create and/or generate reports out of your systems on an <i>ad-hoc</i> basis; and</li> <li>• Reporting back to providers within the network.</li> </ul>	15		
		<p><b>R.11</b> Provide a detailed profile of the key information systems within your span of control.</p>	5		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<b>R.12</b> Provide a profile of your current and proposed Information Systems (IS) organization.	5		
		<b>R.13</b> Describe what you will do to promote and advance electronic claims submissions and assist providers to accept electronic funds transfers.	5		
		<b>R.14</b> Indicate how many years your IT organization or software vendor has supported the current or proposed information system software version you are currently operating. If your software is vendor supported, include vendor name(s), address, contact person and version(s) being used.	Included/Not Included		
		<b>R.15</b> Describe your plans and ability to support network providers' "meaningful use" of Electronic Health Records (EHR) and current and future IT Federal mandates. Describe your plans to utilizing ICD-10 and 5010.	15		
		<b>R.16</b> Describe the procedures that will be used to protect the confidentiality of records in DHH databases, including records in databases that may be transmitted electronically via e-mail or the Internet.	10		

CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>Section S: Added Value to Louisiana Providers and CCN Members</b></p> <p>If you are awarded a contract, the response to this section will become part of your contract with DHH and DHH will confirm your compliance. The incentives and enhanced payments, for providers and expanded benefits to members proposed herein cannot be revised downward during the initial thirty-six (36) month term of the contract, as such programs were considered in the evaluation of the Proposal. Increases in payments or benefits during the term of the contract may be implemented.</p>	200		
		<p><b>S.1</b> The “value added” from Provider Incentive Payments and Enhanced Payments (above the Medicaid rate floor) will be considered in the evaluation of Proposals. Responses to this section (which can be considered Proprietary) will be evaluated based solely on the quantified payment amounts reported herein, based on projected utilization for 75,000 members, and within the guidelines of the CCN program. Any health benefits or cost savings associated with any quality or incentive program shall not be included in this response and will not be considered in the evaluation of this factor. Pursuant to State Rules, the default payments between CCNs and providers are Louisiana Medicaid’</p>	100		

CCN-P REQUEST FOR PROPOSALS

		<p>rates and the CCN must contract at no less than Medicaid rate in effect on the date of service; for example the Medicaid physician fee schedule or Medicaid hospital per diem amounts or FQHC/RHC PPS amounts.</p> <p>Complete RFP <b>Appendix OO</b> to identify circumstances where you propose to vary from the floor reimbursement mechanism.</p> <ul style="list-style-type: none"> <li>• For increased provider payments to be considered in the evaluation, they must represent an increase in the minimum payment rates for all providers associated with the CCN's operating policies and not negotiated rates for a subset of the providers. As an example, if the CCN's physician payment policy is to pay Medicare rates, and possibly negotiate payments above that rate on a case-by-case basis, then the difference between the published Medicaid rate and the Medicare rate would be the quantifiable variance to be reported in this section; if the Medicaid rate was the base rate and anything above that rate subject to negotiation, then such amounts would not qualify for inclusion herein.</li> <li>• If you propose to contract with any providers using methodologies or rates that differ from the applicable Medicaid fee schedules, include such arrangements. By provider type, describe the proposed payment methodologies/rates and quantify the projected per member per month benefit.</li> <li>• The quantified incentives and enhanced</li> </ul>			
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CCN-P REQUEST FOR PROPOSALS

		<p>payments reported should only represent the value exceeding the minimum Medicaid payment equivalent. If any proposals are not explicitly above the Medicaid rates, include a detailed calculation documenting how the minimum Medicaid equivalent was considered in the determination of the incentive/enhanced amount. For example, if the CCN proposes to pay physicians at the Medicare fee schedule during calendar year 2012, the amount reported in the attached would be determined as the projected difference between payments at the Medicare fee schedule and the Medicaid fee schedule, documenting the projected value using the Medicaid fees. Further, if capitation or alternative payments are proposed, the equivalent value of Medicaid fee payments based on projected utilization would be removed in the determination of the enhanced value.</p> <ul style="list-style-type: none"> <li>• Do not include payments for services where Federal or State requirements are currently scheduled to increase payments at a future date. In such circumstances, maintenance of effort will be expected of the CCN. For example, some Medicaid primary care rates are projected to increase to Medicare rates in January of 2013, and the variance between the two types of rates would not qualify as an enhanced/incentive payment after January 1, 2013.</li> <li>• During the evaluation of the proposals, preferences will be given to plans based upon the cumulative amount of quantified provider</li> </ul>			
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CCN-P REQUEST FOR PROPOSALS

		<p>benefit associated with the following:</p> <ul style="list-style-type: none"> <li>○ higher payment rates than the required Medicaid default rate (fee for service or per diem or PPS or sub-capitated/other alternative rate);</li> <li>○ bonus payments above the required Medicaid default rate;</li> <li>○ pay for performance incentive payments above the required Medicaid default rate; and</li> <li>○ other payment arrangements above the required Medicaid “floor” rate.</li> </ul> <ul style="list-style-type: none"> <li>● Payments for case management services may be included if paid to unrelated practitioners, e.g., physicians, clinics, etc.</li> <li>● For bonus pools or Pay For Performance (P4P) programs, describe the eligible categories of provider, the basis for paying the applicable bonus pools and the proposed terms and conditions in the template. You may attach additional information, as appropriate.</li> <li>● Indicate if any bonus pool is to be held in escrow, and if so who will be the escrow agent.</li> <li>● If any part of the proposed bonus pool is to be funded by withhold from subcontracted provider payments, confirm that the initial provider payment net of withhold would not be less than the Medicaid rate.</li> <li>● The completed template and all additional documentation and calculations shall be</li> </ul>			
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CCN-P REQUEST FOR PROPOSALS

		accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information.			
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CCN-P REQUEST FOR PROPOSALS

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		<p><b>S.2</b> Provide a listing, description, and conditions under which you will offer additional health benefits: 1) not included in the Louisiana Medicaid State Plan or 2) beyond the amount, duration and scope in the Louisiana Medicaid State Plan to members.</p> <ul style="list-style-type: none"> <li>• For each expanded benefit proposed:               <ul style="list-style-type: none"> <li>○ Define and describe the expanded benefit;</li> <li>○ Identify the category or group of Members eligible to receive the expanded service if it is a type of service that is not appropriate for all Members;</li> <li>○ Note any limitations or restrictions that apply to the expanded benefit</li> <li>○ Identify the types of providers responsible for providing the expanded benefit, including any limitations on Provider capacity if applicable.</li> <li>○ Propose how and when Providers and Members will be notified about the availability of such expanded benefits;</li> <li>○ Describe how a Member may obtain or access the Value-added Service;</li> </ul> </li> </ul>	<b>100</b>		

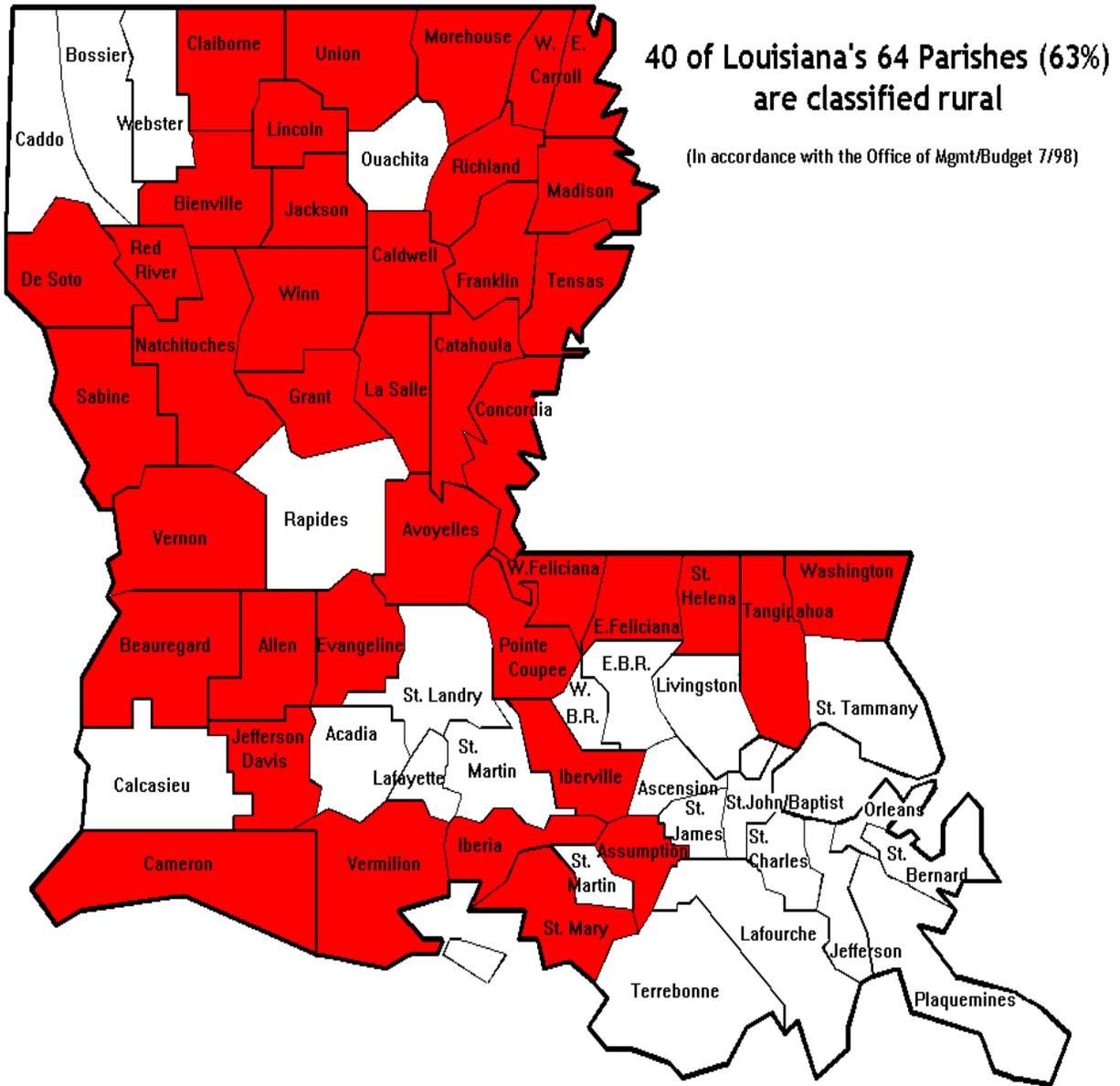
CCN-P REQUEST FOR PROPOSALS

		<ul style="list-style-type: none"> <li>• Include a statement that you will provide the expanded benefits for the entire thirty six (36) month term of the initial contract.</li> <li>• Describe if, and how, you will identify the expanded benefit in administrative data (encounter Data).</li> </ul> <p>Indicate the PMPM actuarial value of expanded benefits assuming enrollment of 75,000 members, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information.</p>			
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## **Appendix LL**

# **Louisiana Rural Parishes Map**

### Louisiana Rural Parishes Map



## **Appendix MM**

# **Attestation of Provider Network Submission**

## CCN-P REQUEST FOR PROPOSALS

(Company Letter Head)

### Attestation of Provider Network Submission

For GSA \_\_\_\_\_ (A, B and/or C)

Date \_\_\_\_\_

I, \_\_\_\_\_, as (Title) for (Name of Company), do hereby attest that the information provided concerning our proposed network (letters of intent and/or subcontracts) is (are) accurate, true, and complete.

I attest that the necessary information for these providers will be loaded into our organization's system prior to providing services to Louisiana Medicaid/CHIP members. Additionally, I attest that the following requirements will be met:

- All subcontracts and amendments will utilize a model sub contract approved by DHH, or any modifications to the model subcontract have been approved by DHH prior to execution,
- All subcontracts will be properly signed, dated and executed by both parties, and
- All provider files will contain information regarding hospital privileges (if appropriate) and a list of group practice members.

In addition to the services provided through its subcontracted network, \_\_\_\_\_ (CCN name) will provide access to enhanced primary care case management and PCP primary care management services consistent with the Contract with DHH.

I understand that should DHH determine at a later date that the submitted information is inaccurate, untrue, or incomplete, (Name of company) may be subject to sanctions and/or fines as outlined in the Contract with DHH.

\_\_\_\_\_  
Signature/Title

\_\_\_\_\_  
Date

# **Appendix NN**

## **Person First Policy**

**COMMUNICATIONS WITH RESPECT TO PERSONS SERVED BY DHH**

**I. Purpose**

This policy is to ensure that in all communications persons with disabilities who are served by the department are referred to in language that is affirmative and respectful.

The intent of this policy is to provide guidance to DHH employees and to provide a foundation for training, information and educational opportunities that produce changes in the language we use that ensures respect for the people we serve.

This policy shall not be used as the basis for any disciplinary action or discrimination against any employee who fails to adopt the elements of the policy described herein.

In addition, the policy is not intended to impede accurate communication about medical diagnoses, but rather, to affirm the dignity of people with disabilities and foster positive attitudes.

**II. Applicability**

This policy applies to all DHH employees.

**III. Implementation**

The effective date of this policy is December 31, 2003. Subsequent revisions shall become effective on the date the revisions are approved and signed by the Secretary.

**IV. Policy**

It is the policy of the Department of Health and Hospitals to use written and oral language that reflects the individuality and dignity of the persons we serve.

- A. The Department recognizes that disability is a natural part of the human experience. It is, like gender and ethnicity, one of many characteristics of being human.
- B. The Department acknowledges that words have power, the power to shape the way people think, feel, and act towards others. When a group of people wants understanding and acceptance, attention to the language used in talking and writing about them is particularly important.
- C. Departmental employees have the opportunity to impact how people with disabilities are viewed, treated and responded to. The Department, therefore, adopts the use of positive language.

Such positive language refers to the person first, and then addresses traits or characteristics. It puts the person before the disability and describes what a person has, not what a person is. Positive language promotes understanding, respect, dignity and affirmative outlooks.

### **V. Guidelines for Using Positive Language**

- A. In preparing documents and presentations and in general oral conversations, each employee of the Department should consider the following:
1. The people we serve are first and foremost multi-dimensional human beings like everyone else but whom, secondarily, have a disorder with which they are dealing. A person does not equate to a disability, i.e., a person may have a condition like mental retardation, but would not be referred to as a mental retardate. Likewise, it is preferable to say that a person has a disability, rather than he is disabled. Phrases such as “developmentally disabled children:” should be replaced by “children with developmental disabilities.”
  2. Ask yourself whether it is necessary to mention disability in all cases. The term should be used only when it is significant to the conversation or understanding of written material.
  3. Emphasis should to be placed on abilities, rather than limitations. Consider, for example, that wheelchairs allow people to be mobile, rather than being confined.
  4. Avoid negative words or those that sensationalize disabilities. Words like “suffer”, “tragedy”, “problem” and “afflicted” are considered offensive.
  5. “Problems” or “deficits” should be framed as needs. This is the traditional way that we refer to the supports we all need to operate, i.e., “I need glasses,” rather than “I have a visual deficit.”
  6. Avoid euphemisms such as “differently-abled,” and “special,” when what is meant is segregated. The exception is where the term “special” is used as a part of a proper name as in “Special Olympics.”
- B. It is not the intent of this policy to impede communications in medical settings. Where the general population would be referred to as “clients,” that same term is properly used in reference to persons with disabilities.

### **VI. Responsibility**

It is the responsibility of each office/division/bureau to promote the use of positive language. The department recognizes, however, the changes demanded in this policy require a cultural shift that will not occur immediately, but over time and with support and training.

## CCN-P REQUEST FOR PROPOSALS

- b. Each office/division/bureau is responsible for providing orientation, training, information and educational materials regarding the use of positive language to its employees.
- c. Within each office/division/bureau, written materials, particularly those that will be shared with the public, are to be reviewed prior to distribution to ensure the use of respectful language. It is also important that positive language be used in individual planning documents and other materials written about specific individuals being served.

### Notations:

A variety of resources were used in the preparation of this policy, including work by Kathie Snow at [www.disabilityisnatural.com](http://www.disabilityisnatural.com), the State of Texas Developmental Disabilities Council, Otto F. Wahl, Ph.D. at George Mason University, and the Nebraska Department of Health and Human Services.

## **Appendix OO**

# **Provider Incentive Payments Template**

## CCN-P REQUEST FOR PROPOSALS

### Louisiana Coordinated Care Networks - Prepaid Provider Incentive Programs

#### Fee for Service Payment Rates

Express all amounts on projected PMPM basis. Provide supporting documentation of how amounts were determined. Amounts should reflect only payments to non-related parties; i.e. exclude all payment variations in which the related party receives the variance.

		PMPM									
		Children and Families									
		Children (Ages 0-18)									
Service	Description of payment methodology (attach additional detail as necessary)	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	
Physician - Primary Care											
Physician - Specialty Care											
Hospital Inpatient - General											
Hospital Inpatient - Psychiatric											
Hospital Outpatient											
Other (specify):											
Other (specify):											
Other (specify):											
Other (specify):											
Other (specify):											
Total											
Projected enrollment											
		PMPM									
		Children and Families									
		Adults (Ages 19+)									
Service	Description of payment methodology (attach additional detail as necessary)	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	
Physician - Primary Care											
Physician - Specialty Care											
Hospital Inpatient - General											
Hospital Inpatient - Psychiatric											
Hospital Outpatient											
Other (specify):											
Other (specify):											
Other (specify):											
Other (specify):											
Other (specify):											
Total											
Projected enrollment											

## CCN-P REQUEST FOR PROPOSALS

### Louisiana Coordinated Care Networks - Prepaid Provider Incentive Programs

#### Sub-Capitation Payment Arrangements

Express all amounts on projected PMPM basis. Provide supporting documentation of how amounts were determined. Amounts should reflect only payments to non-related parties; i.e. exclude all payment variations in which the related party receives the variance.

		PMPM Children and Families Children (Ages 0-18)								
Service	Description of payment methodology (attach additional detail as necessary)	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9
Physician - Primary Care										
Physician - Specialty Care										
Hospital Inpatient - General										
Hospital Inpatient - Psychiatric										
Hospital Outpatient										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Total										
Projected enrollment										
		PMPM Children and Families Adults (Ages 19+)								
Service	Description of payment methodology (attach additional detail as necessary)	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9
Physician - Primary Care										
Physician - Specialty Care										
Hospital Inpatient - General										
Hospital Inpatient - Psychiatric										
Hospital Outpatient										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Total										
Projected enrollment										

## CCN-P REQUEST FOR PROPOSALS

### Louisiana Coordinated Care Networks - Prepaid Provider Incentive Programs

#### Bonus Payments

Express all amounts on projected PMPM basis. Provide supporting documentation of how amounts were determined. Amounts should reflect only payments to non-related parties; i.e. exclude all payment variations in which the related party receives the variance.

		PMPM Children and Families Children (Ages 0-18)								
Service	Description of payment methodology (attach additional detail as necessary)	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9
Physician - Primary Care										
Physician - Specialty Care										
Hospital Inpatient - General										
Hospital Inpatient - Psychiatric										
Hospital Outpatient										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Total										
Projected enrollment										
		PMPM Children and Families Adults (Ages 19+)								
Service	Description of payment methodology (attach additional detail as necessary)	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9
Physician - Primary Care										
Physician - Specialty Care										
Hospital Inpatient - General										
Hospital Inpatient - Psychiatric										
Hospital Outpatient										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Total										
Projected enrollment										

## CCN-P REQUEST FOR PROPOSALS

**Louisiana Coordinated Care Networks - Prepaid  
Provider Incentive Programs**

**Pay for Performance Incentive Payments**

Express all amounts on projected PMPM basis. Provide supporting documentation of how amounts were determined. Amounts should reflect only payments to non-related parties; i.e. exclude all payment variations in which the related party receives the variance.

		PMPM Children and Families Children (Ages 0-18)								
Service	Description of payment methodology (attach additional detail as necessary)	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9
Physician - Primary Care										
Physician - Specialty Care										
Hospital Inpatient - General										
Hospital Inpatient - Psychiatric										
Hospital Outpatient										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Total										
Projected enrollment										
		PMPM Children and Families Adults (Ages 19+)								
Service	Description of payment methodology (attach additional detail as necessary)	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9
Physician - Primary Care										
Physician - Specialty Care										
Hospital Inpatient - General										
Hospital Inpatient - Psychiatric										
Hospital Outpatient										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Total										
Projected enrollment										

## CCN-P REQUEST FOR PROPOSALS

**Louisiana Coordinated Care Networks - Prepaid  
Provider Incentive Programs**

**Other Payment Arrangements**

Express all amounts on projected PMPM basis. Provide supporting documentation of how amounts were determined. Amounts should reflect only payments to non-related parties; i.e. exclude all payment variations in which the related party receives the variance.

		PMPM Children and Families Children (Ages 0-18)								
Service	Description of payment methodology (attach additional detail as necessary)	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9
Physician - Primary Care										
Physician - Specialty Care										
Hospital Inpatient - General										
Hospital Inpatient - Psychiatric										
Hospital Outpatient										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Total										
Projected enrollment										
		PMPM Children and Families Adults (Ages 19+)								
Service	Description of payment methodology (attach additional detail as necessary)	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9
Physician - Primary Care										
Physician - Specialty Care										
Hospital Inpatient - General										
Hospital Inpatient - Psychiatric										
Hospital Outpatient										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Other (specify):										
Total										
Projected enrollment										

# **Appendix PP**

## **Reference Questionnaire**

**CCN-P REQUEST FOR PROPOSALS**

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

**PROPOSAL REFERENCE QUESTIONNAIRE**

**REFERENCE SUBJECT: < INSERT NAME OF PROPOSER>**

The "reference subject" specified above, intends to submit a proposal to the Louisiana Department of Health & Hospitals (DHH) in response to the Request for Proposals (RFP) indicated for Medicaid managed care services through the Louisiana Medicaid Coordinated Care Network Program. As a part of such proposal, the reference subject must include a number of completed and sealed reference questionnaires (using this form).

Each individual responding to this reference questionnaire is asked to follow these instructions:

- complete this questionnaire (either using the form provided or an exact duplicate of this document);
- sign and date the completed questionnaire;
- seal the completed, signed, and dated questionnaire in a new standard #10 envelope;
- sign in ink **across the sealed portion** of the envelope; and
- return the sealed envelope containing the completed questionnaire directly to the reference subject.

**(1) What is the name of the individual, company, organization, or entity responding to this reference questionnaire?**

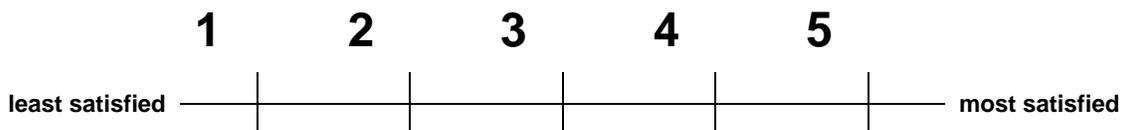
**(2) Please provide the following information about the individual completing this reference questionnaire on behalf of the above-named individual, company, organization, or entity.**

<b>NAME:</b>	
<b>TITLE:</b>	
<b>TELEPHONE #</b>	
<b>E-MAIL ADDRESS:</b>	

**(3) What services does /did the reference subject provide to your company or organization?**

**(4) What is the level of your overall satisfaction with the reference subject as a vendor of the services described above?**

*Please respond by circling the appropriate number on the scale below.*



CCN-P REQUEST FOR PROPOSALS

If you circled 3 or less above, what could the reference subject have done to improve that rating?

(5) If the services that the reference subject provided to your company or organization are completed, were the services completed in compliance with the terms of the contract, on time, and within budget? If not, please explain.

(6) If the reference subject is still providing services to your company or organization, are these services being provided in compliance with the terms of the contract, on time, and within budget? If not, please explain.

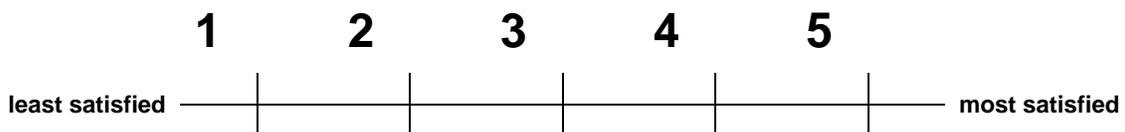
(7) How satisfied are you with the reference subject's ability to perform based on your expectations and according to the contractual arrangements?

(8) In what areas of service delivery does /did the reference subject excel?

(9) In what areas of service delivery does /did the reference subject fall short?

(10) What is the level of your satisfaction with the reference subject's project management structures, processes, and personnel?

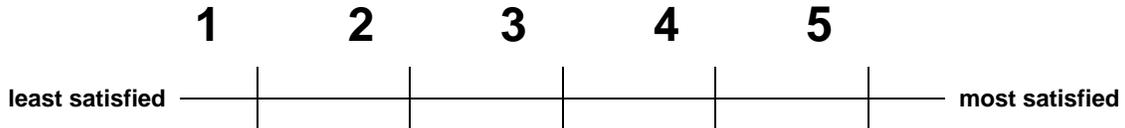
*Please respond by circling the appropriate number on the scale below.*



What, if any, comments do you have regarding the score selected above?

- (11) Considering the staff assigned by the reference subject to deliver the services described in response to question 3 above, how satisfied are you with the technical abilities, professionalism, and interpersonal skills of the individuals assigned?

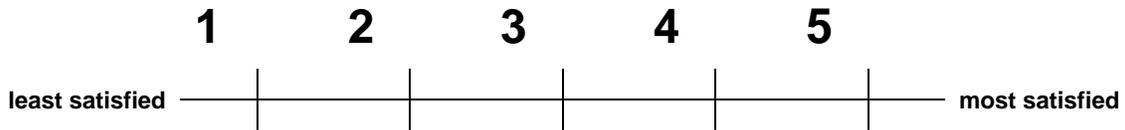
*Please respond by circling the appropriate number on the scale below.*



What, if any, comments do you have regarding the score selected above?

- (12) Would you contract again with the reference subject for the same or similar services?

*Please respond by circling the appropriate number on the scale below.*



What, if any, comments do you have regarding the score selected above?

**REFERENCE SIGNATURE:**

(by the individual completing this request for reference information)

\_\_\_\_\_ (must be the same as the signature across the envelope seal)

**DATE:**

\_\_\_\_\_

**Appendix QQ**  
**CCN-OPH MOU**

## CCN-P REQUEST FOR PROPOSALS

### OPH/CCN Memorandum of Understanding

#### Office of Public Health Memorandum of Understanding Guidelines

The CCN will coordinate its public health-related activities with the Louisiana Office of Public Health (OPH). Coordination mechanisms and operational protocols for addressing public health issues will be negotiated with OPH and BHSF (Medicaid) and reflect Louisiana public health priorities. The coordination of activities related to public health will take the form of agreements among the parties which may include policy memos or separate memorandums of understanding signed by OPH, BHSF (Medicaid), and the CCNs. Public health-related activities include, but are not limited to:

- Sexually transmitted diseases
- Human immunodeficiency virus (HIV/AIDS) prevention and treatment
- Tuberculosis
- Immunization
- WIC (Supplemental Nutrition Program for Women, Infants, and Children)
- Family planning
- Maternal and child health (MCH)
- Children's Special Health Services (Louisiana's program for children with special health care needs)
- Population-based services

MOU's will cover the following topics with regard to the public health activities:

- Statement of common goals, priority populations and conditions and measurable objectives
- Inter-organizational communication protocols
- Data sharing and reporting
- Coordination of outreach and education
- Population health assessments
- Case management for high-risk populations (TB, HIV/AIDS, STD, NFP)
- Technical assistance
- Special projects (e.g., mutual pursuit of grants)
- Attachment: List of public health resources in region and identification of those that are "in network"