

MODEL



**DEPARTMENT OF
HEALTH**

AND HOSPITALS

Medicaid

PROVIDER AGREEMENT

BETWEEN

**THE LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING**

AND

(Name of CCN-P)

**For the provision of services in the
Louisiana Medicaid Coordinated Care Program**

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This Provider Agreement is between the Louisiana Department of Health and Hospitals – Bureau of Health Services Financing and _____ (name of Coordinated Care Network) for the provision of medical services under Medicaid’s Coordinated Care Network - Prepaid Program. This agreement is in compliance with 45 CFR §92.36(a).

This Provider Agreement is entered into as of the first day of _____ (month), 20____, between the Department of Health and Hospitals, hereinafter referred to as "DHH", and the Coordinated Care Network – Prepaid, hereinafter referred to as “CCN or CCN-P”.

1 GENERAL PROVISIONS

1.1 Effective Date and Term

The Provider Agreement (which includes the PE-50/CCN-P and its appendices), hereby incorporated, contains all of the terms and conditions agreed upon by the parties.

This Provider Agreement shall be effective the date the CCN passes the CCN Enrollment Process (*See CCN-P Policy and Procedure Guide*) and is approved by DHH. The term period of the Provider Agreement shall begin on the initial date of service implementation, as specified by DHH, for a three (3) year commitment from the initial date of startup; unless terminated prior to that date in accordance with state or federal law or terms of the Provider Agreement.

Upon mutual agreement of both parties, this Provider Agreement may be renewed for a subsequent additional three (3) year period.

The CCN is aware of all documents referenced in this Provider Agreement. These documents are on file in the Medicaid Office and/or on Making Medicaid Better website.

1.2 Notices

Whenever notice, as specified in this Provider Agreement (e.g. termination or amendment) is required to be given to the other party, it shall be made in writing and delivered to that party. Delivery shall be deemed to have occurred if made in person and a signed receipt is obtained or three (3) calendar days have elapsed after posting if sent by registered or certified mail, return receipt requested.

Notices shall be addressed as follows:

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In case of notice to CCN:

_____.

_____.

In case of notice to DHH:

Louisiana Department of Health and Hospitals
Bureau of Health Services Financing
628 North Fourth Street
Post Office Box 90130
Baton Rouge, Louisiana 70821-9030
Attn: Medicaid Coordinated Care Section Chief

Either party may change its address for notification purposes by mailing a notice stating the change, effective date of change and setting forth the new address at least 10 days prior to the effective date of the change of address. If different representatives are designated after execution of this Provider Agreement, notice of the new representative will be given in writing to the other party and attached to originals of this Provider Agreement.

1.3 Definitions

The terms used in this Provider Agreement, shall be construed and interpreted as defined in Appendix A unless the context clearly requires otherwise.

1.4 Entire Agreement

The CCN shall comply with all provisions of the Provider Agreement, including addenda, amendments and appendices, and shall act in good faith in the performance of the provisions of said Provider Agreement. The CCN shall be bound by Medicaid policy as stated in applicable provider manuals, *CCN-P Policy and Procedure Guide, any and all Companion Guides* and with any updates or amendments thereto. The CCN agrees that failure to comply with the provisions of this Provider Agreement may result in the assessment of monetary penalties, sanctions and/or termination of the Provider Agreement in whole or in part, as set forth in this Provider Agreement. The CCN shall comply with all applicable DHH policies and procedures in effect throughout the duration of this Provider Agreement period. The CCN shall comply with all DHH provider manuals, policy and procedure guides, rules and regulations, and bulletins relating to the provision of services under this Provider Agreement. Where the provisions of the Provider Agreement differ from the requirements set forth in

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the handbooks and/or manuals, the Provider Agreement provisions shall control.

DHH, at its discretion, will issue Medicaid bulletins to inform the CCN of changes in policies and procedures which may affect this Provider Agreement. Unless otherwise specified in the Medicaid bulletin the CCN will be given sixty (60) calendar days to implement such changes. DHH is the only party to this Provider Agreement which may issue Medicaid bulletins.

1.5 Federal Approval of Provider Agreement

The CMS Regional Office shall review and approve all risk-bearing CCN Provider Agreements, including those risk Provider Agreements that, on the basis of their value, are not subject to the prior approval requirements in 42 CFR§438.806. CMS has final authority to approve this comprehensive risk-based Provider Agreement between DHH and the CCN in which payment hereunder exceeds one million dollars (\$1,000,000.00). If CMS does not approve this Provider Agreement entered into under the Terms & Conditions described herein, the Provider Agreement will be considered null and void.

1.6 Renewal

This Provider Agreement may be renewed for an additional three year period, whenever either of the parties hereto provides the other party with one hundred and twenty (120) calendar days advance notice of intent to renew and written agreement to renew the Provider Agreement is obtained from both parties. Either party may decline to renew this Provider Agreement for any reason. The parties expressly agree there is no property right in this Provider Agreement.

1.7 Amendments

This Provider Agreement may be amended at any time as provided in this paragraph. This Provider Agreement may be amended whenever appropriate to comply with state and federal requirements or state budget reductions provided however that rates must be certified as actuarially sound. No modification or change of any provision of the Provider Agreement shall be made or construed to have been made unless such modification is mutually agreed to in writing by the CCN and DHH, and incorporated as a written amendment to this Provider Agreement prior to the effective date of such modification or change. Any amendment to this Provider Agreement shall require approval by DHH, and CMS Regional Office prior to the amendment implementation.

1.8 Overview

Beginning in 2011, DHH will phase-in implementation of services through Medicaid's Coordinated Care Program. A Coordinated Care Networks-Prepaid is a risk-bearing, pre-paid health care delivery system responsible for providing specified Medicaid State Plan services to Medicaid enrolled members in their designated service area.

The initial implementation of the Coordinated Care Program will be phased in based on DHH's administrative regions. (See *CCN-P Policy and Procedure Guide* for Implementation Schedule)

A prepaid CCN assumes risk for the cost of the services core benefits and services under this Provider Agreement and incurs loss if the cost of furnishing these core benefits and services exceeds the payment received for providing these services.

Through this Provider Agreement, the CCN and their network of providers will provide DHH with the ability to ensure accountability while improving healthcare access, coordinating care and promoting healthier outcomes.

CCNs are a part of the continuum in DHH's strategy to move toward a more accountable, quality focused model of care. This effort is in line with national health care reform efforts to control costs, provide greater access to quality health care services and accountability both at the provider and enrollee level.

The CCN shall provide a patient-centered medical home system of care for DHH, in accordance with this Provider Agreement and *CCN-P Policy and Procedure Guide*. The CCN must demonstrate the capacity to manage targeted populations identified in **§6.1 Enrollment Populations** of this Provider Agreement through:

- a. Medical Management/Prior Authorization;
- b. Customer Service;
- c. Quality Management;
- d. Provider Monitoring;
- e. Patient Centered Medical Homes; and
- f. Monitoring and Reporting.

The CCN shall be responsible for network provider monitoring to ensure requirements such as, but not limited to: access to care; provider's compliance with the CCN policies; and progress of practices regarding implementation of patient-centered medical homes. The CCN shall provide participating primary care practices with support necessary to transition the practice, at a minimum, to entry level patient-centered medical home recognition through the progression to the highest level of recognition (e.g. education, training, tools, and provision of data

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relevant to patient clinical care management and systems development); and facilitate data interchange between practices and the CCN, and the CCN and DHH (e.g. performance measures).

DHH shall establish a per member per month (PMPM) actuarially sound risk-adjusted rate to be paid to the CCN. The rates shall not be subject to negotiation or dispute resolution. The rate is intended to cover all benefits and management services outlined in this Provider Agreement. Management services include but are not limited to:

- Utilization Management
- Quality Management and Compliance
- Prior Authorization
- Provider Monitoring
- PCP Patient-Centered Medical Home Recognition
- Member and Provider Services
- PCP Primary Care Case Management
- Fraud and Abuse Monitoring and Compliance
- Case Management
- Chronic Care Management
- Account Management and Overhead

A CCN must meet the following prerequisite criteria in order to participate as a CCN provider in DHH's Coordinated Care Network - Prepaid program:

- a. Meets the federal definition of an MCO as defined in 42 CFR §438.2;
- b. Meets the requirements of La. R. S. 22:1016 and is licensed or has a Certificate of Authority from the Louisiana Department of Insurance pursuant to Title 22 of the Louisiana Revised Statutes;
- c. Is certified by the Louisiana Secretary of State to conduct business in the state of Louisiana;
- d. Meets solvency standards as specified in 42 CFR §438.116 and Title 22 of the Louisiana Revised Statutes;

- e. Meets NCQA or URAC Health Plan Accreditation or agrees to submit application for accreditation at the earliest possible date as allowed by NCQA or URAC and once achieved, maintains accreditation through the life of this Agreement;
 - e. Has network capacity to enroll not less than 25,000 Medicaid eligibles into the network; and
 - f. Successfully passes the CCN Enrollment Process (*See CCN-P Policy and Procedure Guide*).
- 1.9 Moral or Religious Objections to Providing Certain Core Benefits and Services**

Pursuant to federal law, health care providers may choose not to provide certain medical services (i.e., abortion, sterilization, family planning) due to moral or religious objections. If the CCN chooses not to provide its members with these State Plan medical services, which are covered services under the Louisiana Medicaid Program, the CCN must provide the CCN's members with these services through other arrangements as specified in the Louisiana State Plan for Medical Assistance. The CCN's PMPM payment amounts include sufficient funding for the services. The CCN is exempt from certain Provider Agreement requirements, such as providing reports associated with these services. Any exemptions from Provider Agreement requirements will be specifically identified in this Provider Agreement (See §4.1.6) and/or the *CCN-P Policy and Procedure Guide*.

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2.0 FINANCIAL MANAGEMENT

The CCN shall be responsible for sound fiscal management of benefits and services provided under this Provider Agreement.

2.1 Reimbursement - General Provisions

DHH shall make prospective monthly prepaid risk-adjusted payments for each member enrolled into the CCN.

The CCN shall enroll as a Louisiana Medicaid provider (PE 50 - CCN-P) and as per 42 CFR §438.106 (a),(b) and(c), agree to accept, as payment in full, the actuarially sound rate established by DHH pursuant to this agreement, 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 July until the first Medicaid Management Information System (MMIS) payment cycle in July to comply with state fiscal policies and procedures.

In the event the federal government lifts any moratorium on supplemental payments to physicians or facilities, PMPM rates in this Provider Agreement may be adjusted accordingly.

2.1.1 Annual Actuarial Study

DHH may retain a qualified actuary to conduct an annual actuarial study of the Coordinated Care Program. The CCN shall provide in writing any information requested by DHH to assist the actuary in completion of the annual actuarial study. DHH will give the CCN reasonable time to respond to the request and full cooperation by the CCN shall not unreasonably be withheld. DHH will make the final determination as to what is considered reasonable.

2.1.2 Maternity Kick Payments

In addition to the PMPM rate, DHH shall provide CCNs a one-time supplemental lump sum payment for each obstetrical delivery. This kick payment is intended to cover the cost of prenatal care, the delivery event, and post-partum care and normal newborn hospital costs. This payment will be paid to the CCN upon submission of satisfactory evidence of the occurrence of a delivery. The hospital shall **accurately** input into the Louisiana Electronic Event Registration System (LEERS) the delivery event, as evidence that a delivery event has taken place, in order for a kick payment request to be initiated to DHH's fiscal

intermediary (FI) for payment to the CCN. Only one maternity kick payment will be made per delivery event. Therefore, multiple births during the same delivery will still result in one maternity kick payment being paid. The maternity kick payment will be paid for both live and still births. The amount of the kick payment will be determined by DHH's actuary.

2.1.3 CCN Payment Schedule

The risk-adjusted PMPM payment shall be based on member enrollment paid on the dates indicated in the *CCN-P Policy and Procedure Guide* (Appendix GG - Fiscal Intermediary Payment Schedule). Member enrollment is determined by the total Medicaid/CHIP eligibles assigned to the CCN as of the third (3rd) working day from the end of the previous month. For age group assignment purposes, age will be defined as of the beginning of the month for which the PMPM payment is intended. The CCN shall make payments to its providers as stipulated in **§ 2.2.4 and §14.44, §14.45.**

No payment to the CCN by DHH may be assigned by the CCN. This does not prohibit the CCN from arranging sub-prepaid payments to CCN network providers.

The CCN shall agree to accept payments as specified in this section and have written policies and procedures for receiving and processing PMPM payments and adjustments. Any charges or expenses imposed by financial institutions for transfers or related actions shall be borne by the CCN.

2.1.4 Payment Adjustments

In the event that an erroneous payment was made to the CCN, DHH shall reconcile the error, by adjusting the CCNs next monthly prepaid payment.

Retrospective adjustments to prior payments may occur when it is determined that a member's aid category was changed. Payment adjustments may only be made when identified within twelve (12) months from the date of the member's aid category change for all services delivered within the twelve (12) month time period. If the member switched from a CCN eligible aid category to a CCN excluded aid category, previous PMPM payments will be recouped from the CCN.

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The CCN will recoup payments made to the providers. The CCN shall instruct the provider to resubmit the claim(s) through Medicaid MMIS directly and DHH will pay the claim subject to the twelve (12) month limitation described above, after recoupment of the PMPM has been made. In order for the provider to be reimbursed by DHH they must be enrolled with Medicaid.

The CCN will refund prospective payments received from DHH for a deceased member after the month of death. DHH will recoup the refund due to DHH as specified in §2.5 of the Provider Agreement.

The entire PMPM payment will be paid during the month of birth and month of death. PMPM payments shall not be pro-rated to adjust for partial month eligibility as this has been factored into the rates.

2.1.5 Risk Sharing

The CCN shall assume one hundred percent (100%) liability for any expenditure above the prepaid PMPM rate and may retain any monies from the PMPM remaining after paying for all expenses. (See §2.1.7)

2.1.6 Determination of Rates

Actuarially sound rates will be determined by DHH acting on the advice of its actuaries. It is intended that rates will initially be set using historical FFS data, with appropriate adjustments for the expected impact of managed care on the utilization of the various types of services (some increases and some reductions) and for the expected cost of CCN administration and overhead. As the Coordinated Care Program matures and FFS data is no longer available, there will be increasing reliance on encounter data and/or financial data to set future rates, subject to comparable adjustments.

The CCN shall be paid in accordance with the prepaid PMPM rates specified in Appendix D of this Provider Agreement and updated consistent with timelines noted in the *CCN-P Policy and Procedure Guide*. The rates will be reviewed and adjusted periodically. These rates shall be actuarially sound and consistent with requirements set forth in 42 CFR §438.6 (c)(2005, as amended).

The rates will be risk adjusted, where applicable, to reflect risk differences across CCNs due to the medical conditions of members within each CCN (See *CCN-P Policy and Procedure Guide*). The risk differences across

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CCNs and the resulting risk-adjusted rates will be updated periodically, using a schedule published by DHH.

The rates may also be adjusted due to the inclusion or removal of a covered Medicaid service(s) not incorporated in the PMPM rate; and/or based on legislative appropriations and budgetary constraints. Any adjusted rates must continue to be actuarially sound and will require an amendment to the Provider Agreement that is mutually agreed upon by both parties.

DHH will provide the CCN with three (3) months advance notice of any major revision to the risk-adjustment methodology. (See *CCN-P Policy and Procedure Guide* for description of methodology) The CCN will be given up to fourteen (14) days to provide input on the proposed changes. DHH will consider the feedback from the CCNs in the changes to the risk adjustment methodology.

2.1.7 Medical Loss Ratio

The CCN shall provide a separate schedule reporting the CCN's medical loss ratio for services provided and reimbursement received under this agreement as specified in the *CCN-P Policy and Procedure Guide*.

2.2 CCN Payment to Federally-Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

2.2.1 The PMPM rate includes an amount equal to the Prospective Payment System (PPS) rate for each visit historically included in the FFS system.

2.2.2 The CCN shall reimburse FQHCs/RHCs based upon rates no less than the Medicaid Prospective Payment Rates established by DHH and in effect on the date of service for each visit established. CCNs are not allowed to sub-capitate these providers by paying them a PMPM rate.

2.2.3 CCNs may elect to make payment to the FQHC/RHC provider at a level and amount that exceeds the minimum requirements described in § 2.2.2, above.

2.2.4 CCNs shall use their best judgment in determining the medical appropriateness and necessity of services performed at an FQHC/RHC. However, CCNs are not allowed to divert members away from FQHCs/RHCs in their networks solely because the same service can be provided at a lower cost at an alternative setting. DHH will monitor

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utilization of FQHCs/RHCs before and after implementation of the CCN program. If there is evidence the CCN is diverting members away from FQHCs/RHCs to alternative settings solely because of cost, the CCN may be subject to sanctions. DHH will reconcile the CCN's payments to the FQHCs/RHCs on a quarterly basis to ensure that the PPS rate was paid and that no supplemental payments are required. If it is determined that supplemental payments are required, DHH will notify the CCN of the amount of the supplemental payments it is to provide to the FQHC/RHC(s).

2.2.5 The CCN shall submit the quarterly report detailing name and specific encounter data of each FQHC/RHC and detailed Medicaid encounter data (i.e. Medicaid recipient data, payment data, service/CPT codes) paid to each FQHC/RHC by month of service to DHH for reasonable cost-based reconciliation. This information shall be submitted in the format required by DHH.

2.2.6 While prepaid CCNs are generally not at risk for specialized behavioral health services, which are described in §4.11.1.2 of the Provider Agreement, prepaid CCNs will be responsible for paying all behavioral health service claims (both basic and specialized behavioral health) provided at a FQHC/RHC at the appropriate encounter rate.

2.3 Co-payments

Any cost sharing imposed on Medicaid members must be in accordance with 42 CFR §447.50 through 447.58 and cannot exceed cost sharing in the Louisiana Medicaid State Plan; however, there are currently no cost sharing requirements for the Coordinated Care Program.

2.4 Ancillary Services Provided at the Hospital

Ancillary services which are provided in a hospital include, but are not limited to, radiology, pathology, emergency medicine and anesthesiology. The CCN shall reimburse the professional component of these services at the Medicaid fee-for-service rate to in-network providers, unless another reimbursement rate has been previously negotiated, when a CCN provider authorizes these services (either in-patient or out-patient). This provision applies to emergency services rendered by non-network providers for ancillary services provided in a hospital setting.

2.5 Return of Funds

The CCN agrees that all amounts owed to DHH, as identified through routine or investigative reviews of records or audits conducted by DHH or other state or federal agency, are due no later than 30 calendar days following notification to the CCN by DHH unless otherwise authorized in writing by DHH. DHH, at its discretion, reserves the right to collect amounts due by withholding and applying all balances due to DHH to future PMPM payments. DHH reserves the right to collect interest on unpaid balances beginning thirty (30) calendar days from the date of initial notification. The rate of interest charged will be the same as that fixed by the Secretary of the United States Treasury as provided for in 45 CFR §30.13. This rate may be revised quarterly by the Secretary of the Treasury and is published by HHS in the Federal Register. In addition, the CCN shall reimburse all payments as a result of any federal disallowances or sanctions imposed on DHH as a result of the CCN's failure to abide by the terms of the Provider Agreement. The CCN shall be subject to any additional conditions or restrictions placed on DHH by the United States Department of Health and Human Services (HHS) as a result of the disallowance. Instructions for returning of funds shall be provided by written notice.

2.6 Third Party Liability (TPL)

The Medicaid program by law is intended to be the payer of last resort; that is, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. Examples of third parties which may be liable to pay for services include, but are not limited to, group health plans, self-insured plans, managed care organizations, pharmacy benefit managers, Medicare, court-ordered health coverage, settlements from a liability insurer, workers' compensation, first party probate-estate recoveries, long-term care insurance, and other state and federal programs (unless specifically excluded by federal statute). Group health plans are regulated by State Insurance Commissioners. Self-insured plans are covered by the Employee Retirement Income Security Act of 1974 (ERISA). The Department of Labor is responsible for overseeing the fiduciary aspects of ERISA.

Individuals eligible for Medicaid assign their rights to third party payments to the State Medicaid agency. States or designated entity are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the State plan.

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In general, if a State or designated entity has determined that a potentially liable third party exists, it must attempt to ensure that the provider bills the third party first before sending the claim to Medicaid. This is known as "cost avoidance." Whenever a State has paid claims and subsequently discovers the existence of a liable third party it must attempt to recover the money from the liable third party. This is known as "pay and chase." Rules for Labor and Delivery, EPSDT (CFR 433.139)

The agency may pay the full amount allowed under the agency's payment schedule for the claim and then seek reimbursement from any liable third party to the limit of legal liability if the claim is for labor and delivery and postpartum care. (Costs associated with the inpatient hospital stay for labor and delivery and postpartum care must be cost-avoided.)

The agency must pay the full amount allowed under the agency's payment schedule for the claim and seek reimbursement from any liable third party to the limit of legal liability (and for purposes of paragraph (b)(3)(ii) of this section, from a third party, if the third party liability is derived from an absent parent whose obligation to pay support is being enforced by the State title IV-D agency), consistent with paragraph (f) of this section if:

(i) The claim is prenatal care for pregnant women, or preventive pediatric services (including early and periodic screening, diagnosis and treatment services provided for under part 441, subpart B of this chapter), that is covered under the State plan; or

(ii) The claim is for a service covered under the State plan that is provided to an individual on whose behalf child support enforcement is being carried out by the State title IV-D agency. The agency prior to making any payment under this section must assure that the following requirements are met: (A) The State plan specifies whether or not providers are required to bill the third party.^{[1][1]}

2.6.1 Responsibility for Identifying and Pursuing Third Party Liability

DHH has delegated its responsibility to the CCN. The CCN shall be responsible for identifying other insurance for their enrolled members. If the CCN identifies other coverage (private or Medicare) they are required to notify DHH monthly. If the Department identifies coverage for a member the Enrollment Broker will be notified through the monthly 820 roster process.

The CCN has sixty (60) days to bill and the private or Medicare carrier, from date of discovery of other coverage. The CCN will be allowed to

retain any payments it collects. The CCN will be required to include the collections in the encounter data submitted to DHH, including any retrospective findings via encounter adjustments. DHH will utilize the data in calculating the CCN's future PMPMs.

2.6.2 States Right to Conduct Identification and Pursuit of Third Party Liability

If the CCN has not collected, within the one-hundred eighty (180) days, from the other insurance DHH may invoke its right to pursue recovery. The CCN will be responsible for all administrative cost associated with this collection. CCN shall be required to provide all claim information for these individuals through encounter data.

2.6.3 Casualty Insurance, Tort Claims and Settlements or Personal Injury

In accordance with 42 CFR §433.138(e), the CCN shall be responsible for identifying any accident or injury utilizing diagnosis and trauma related codes 800 through 999 excluding 994.6. The CCN will take responsibility for identifying and pursuing third party liability for Medicaid eligibles that are enrolled in their network with casualty insurance, tort claims and settlements or personal injury. The CCN shall be required to seek subrogation amounts greater than five hundred dollars (\$500) as required by Louisiana State Plan and federal Medicaid guidelines. The amount of any subrogation recoveries collected by the CCN outside of the claims processing system shall be treated by the CCN as offsets to medical expenses for the purposes of reporting.

The CCN has an affirmative duty to inform DHH of any casualty insurance, tort claims and settlements or personal injury coverage. The PMPM rate for the CCN shall be adjusted to reflect projected recoupments. At DHH's request, the CCN must provide such information not included in encounter data submissions that may be necessary for the administration of third party liability activity. The information must be provided within thirty (30) calendar days of DHH's request. Such information may include, but is not limited to, individual medical records for the express purpose of a third party liability resource to determine liability for the services rendered.

2.6.4 Demonstrate Effort to Collect and Seek Health Insurance by CCN

The CCN shall demonstrate, upon request, to DHH that reasonable effort has been made to seek, collect and/or report third party recoveries. DHH shall have the sole responsibility for determining whether or not

reasonable efforts have been demonstrated. Said determination shall take into account reasonable industry standards and practices.

2.6.5 Submittal of Monthly Reports of Health Insurance Collections

The CCN shall provide to DHH any third party resource information necessary in a format and media described by DHH and shall cooperate in any manner necessary, as requested by DHH, with DHH and/or a cost recovery vendor of DHH.

2.6.5.1 The CCN is required to report members with third party coverage to DHH on a monthly basis by the fifteenth (15th) working day of the month. Specifications of the report will be in the *CCN-P Policy and Policy Guide*.

2.6.5.2 The CCN shall report all cost avoidance values to DHH in accordance with federal guidelines. Specifications of the report will be in the *CCN-P Policy and Policy Guide*.

2.6.6 Submittal of Annual Reports of all Health Insurance Collections

CCNs are required to submit an annual report of all health insurance collections for its members as specified in the *CCN-P Policy and Procedure Guide*, plus copies of any 1099's received from insurance companies for that period of time.

2.7 Workers' Compensation Insurance

Before the Provider Agreement is implemented, the CCN shall obtain and maintain during the life of the Provider Agreement, Workers' Compensation Insurance for all of the CCN's employees that provide services under the Provider Agreement.

The CCN shall require that any contractor and/or contract providers obtain all similar insurance prior to commencing work.

The CCN shall furnish proof of adequate coverage of insurance by a certificate of insurance submitted to DHH during the CCN Enrollment Process and annually thereafter or upon change in coverage and/or carrier.

DHH shall be exempt from and in no way liable for any sums of money that may represent a deductible in any insurance policy. The payment of such a deductible shall be the sole responsibility of the CCN, contractor and/or provider obtaining such insurance.

Failure to provide proof of adequate coverage before work is commenced may result in this Agreement being terminated.

2.8 Commercial Liability Insurance

The CCN shall maintain during the life of this Provider Agreement such Commercial Liability Insurance which shall protect the CCN, and DHH, during the term covered by the Provider Agreement from claims for damages for personal injury, including accidental death, as well as for claims for property damages, which may arise from services related to the Provider Agreement, whether such services are provided by the CCN or by its contractors, or by anyone directly or indirectly employed by either of them, or in such a manner as to potentially impose liability to DHH. In the absence of specific regulations, at a minimum, the amount and type of coverage shall include bodily injury, property damage, errors and omissions, directors' and officers' coverage, and contractual liability, with combined single limits of one million dollars (\$1,000,000).

2.9 Performance Bond

Prior to on-site CCN Enrollment Process - Readiness Review, the CCN shall procure and submit a Performance Bond in the amount of one million dollars (\$1,000,000) or in lieu of a performance bond the CCN may submit an irrevocable letter of credit for the required amount.

DHH shall re-evaluate performance bond requirements within six (6) months of acceptance of the Provider Agreement and implementation of delivery of services and every twelve (12) months thereafter or as deemed necessary by DHH. The CCN shall be required to maintain a performance bond in the amount equal to three (3) months of PMPM payments, or one million dollars (\$1,000,000) whichever is the greater amount. The bond must be obtained from an agent licensed in Louisiana and appearing on the United States Department of Treasury's list of approved sureties. The performance bond must be made payable to the State of Louisiana. The Provider Agreement and dates of performance must be specified in the performance bond. In the event that DHH exercises an option to renew the Provider Agreement for an additional period, the CCN shall be required to maintain the validity and enforcement of the bond for the said period, pursuant to the provisions of this paragraph, in an amount stipulated at the time of Provider Agreement renewal.

2.10 Protection against Insolvency

In the event that the CCN becomes insolvent as determined by the Louisiana Department of Insurance pursuant to Title 22 of the Louisiana Revised Statutes,

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pursuant to the provisions of 42 CFR 438.106 Medicaid members shall not be held liable for any cost incurred by the CCN pursuant to the provisions of 42 CFR §438.106. The CCN shall, at all times, maintain capitalization and surplus requirements in the same amount and method as those requirement(s) set forth in Title 22 of the Louisiana Revised Statutes.. The CCN shall submit proof of Insolvency Protection Account approved by Louisiana Department of Insurance as required in the CCN Enrollment Process.

The CCN shall provide continuing proof of solvency, as required by the Louisiana Department of Insurance, to DHH each provider agreement year.

2.11 Stop Loss Insurance

The CCN shall participate in a stop loss protection program in accordance with R.S. 22:452(1)(a) The CCN shall submit a copy of the third party reinsurance contract to DHH prior to its execution of this Provider Agreement and initial Medicaid enrollment.

2.12 Proof of Insurance

At any time, upon the request of DHH or its designee, the CCN shall provide proof of insurance required in this Provider Agreement and the CCN shall be the named insured on the insurance policy or policies.

2.13 Fidelity Bonds

The CCN shall secure and maintain during the life of this Provider Agreement a blanket fidelity bond from a company doing business in the State of Louisiana on all personnel in its employment. The bond shall include but not be limited to coverage for losses sustained through any fraudulent or dishonest act or acts committed by any employees of the CCN and its contractors.

2.14 Reinsurance

The CCN shall hold a certificate of authority from the Department of Insurance and file all contracts of reinsurance, or a summary of the plan of self-insurance. All reinsurance agreements or summaries of plans of self-insurance shall be filed with the reinsurance agreements and shall remain in full force and effect for at least thirty (30) calendar days following written notice by registered mail of cancellation by either party to DHH or designee. The CCN shall maintain reinsurance agreements throughout the Provider Agreement period, including any extensions(s) or renewal(s). The CCN shall provide prior notification to DHH of its intent to purchase or modify reinsurance protection for certain

members enrolled under the CCN. The CCN shall provide to DHH, the risk analysis, assumptions, cost estimates and rationale supporting its proposed reinsurance arrangements for prior approval. If any reinsurance is provided through related parties, disclosure of the entities and details causing the related party relationship shall be specifically disclosed.

2.15 Errors and Omissions Insurance

The CCN shall obtain, pay for, and keep in force for the duration of the Provider Agreement period, Errors and Omissions insurance from a company doing business in the State of Louisiana, in the amount of at least one million dollars (\$1,000,000.00), per occurrence.

2.16 Disclosure of Related Party Transactions

The CCN shall disclose all related party transactions on a quarterly basis. This disclosure shall include a description of the nature of the relationship as well as the amount of the transaction as specified in the *CCN-P Policy and Procedure Guide*.

2.17 Management Services Contractor(s) Reviews

All management services contractors that have oversight responsibilities for any portion of CCN operations are required to have an annual review. A copy of this review shall be submitted to DHH within one hundred twenty (120) days after year end. An audit will not be required if services billed for by a consultant or actuary is less than fifty thousand dollars (\$50,000) annually.

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3 CCN's ADMINISTRATION AND MANAGEMENT

3.1 CCN Administration and Management

The CCN shall be responsible for the administration and management of its requirements and responsibilities under this Provider Agreement and the *CCN-P Policy and Procedure Guide*, including all contracts, employees, agents, and anyone acting for or on behalf of the CCN. No contract or delegation of responsibility shall terminate the legal responsibility of the CCN to DHH to assure that all requirements are carried out.

The CCN shall have a centralized executive administration located in the state of Louisiana, which shall serve as the contact point for DHH, except as otherwise specified in this Provider Agreement.

The positions described below represent the minimum management staff requirements for the CCN. The CCN shall report changes in management staff to DHH within five (5) business days of the change. The CCN is responsible to ensure that all employees meet qualification requirements commensurate with their staffing position. The CCN is responsible for conducting background checks on all personnel and immediately providing the staffing plan(s) to DHH upon request. The CCN shall not make a change in key personnel as specified in the Provider Agreement, without the prior written consent of DHH.

3.1.1 Staff Requirements

The staffing for the CCN provides for core benefits and services under this Provider Agreement must be capable of fulfilling the requirements of this Provider Agreement, and in accordance this agreement and the *CCN-P Policy and Procedure Guide*. The minimum staffing requirements are as follows:

3.1.1.1 Executive Director

The CCN shall designate an Executive Director to work directly with DHH. The Executive Director shall be a full-time employee of the CCN with authority to revise processes or procedures and assign additional resources as needed to maximize the efficiency and effectiveness of services required under the Provider Agreement. The CCN shall meet in person, or by telephone, at the request of Department representatives to discuss the status of the Provider Agreement, CCN performance, benefits to the state, necessary revisions, reviews, reports and planning.

3.1.1.2 Project Director

The CCN shall have a full-time Project Director (full-time administrator) specifically identified to administer the day-to-day business activities of the Provider Agreement. The CCN may designate the Executive Director, or Medical Director as the fulltime Project Director, but such person cannot also be designated to any other position in this section, including in other lines of business within the CCN, unless otherwise approved by DHH.

3.1.1.3 Medical Director

The CCN shall have a full-time (32 hours/week) with an active unencumbered Louisiana license in accordance with state laws and regulations to serve as medical director to oversee care management and be responsible for the proper authorization and provision of core benefits and services to Medicaid CCN members under this Provider Agreement. The medical director cannot be designated to serve in any other non-administrative position. The Medical Director must have substantial involvement in the Quality Assessment and Performance Improvement (QAPI) activities and shall chair the QAPI committee.

3.1.1.6 Clinical Services Coordinator

The CCN shall have a full-time RN or PA or MD with an active, unencumbered Louisiana license in accordance with state laws and regulations to supervise care management staff.

3.1.1.5 Compliance Officer

The CCN shall have a full-time designated person qualified by training and experience in health care or risk management, to oversee a fraud and abuse program to prevent and detect potential fraud and abuse activities pursuant to state and federal rules and regulations, and carry out the provisions of the compliance plan, including fraud and abuse policies and procedures, investigating unusual incidents and implementing any corrective action plans.

3.1.1.6 Quality Management Director and Staff

The CCN shall have a designated person, qualified by training and experience in Quality Management (QM) and who holds the appropriate clinical certification and/or license.

The CCN shall also have sufficient staff qualified by training and experience to be responsible for the operation and success of the QAPI. The QAPI staff shall be accountable for quality outcomes in all of the CCN's own network providers, as well as contract providers, as stated in 42 CFR §438.200 - 438.242;

3.1.1.7 Data Processing and Data Reporting Coordinator and Staff

The CCN shall have a person trained and experienced in data processing, data reporting, and claims resolution, as required, to ensure that computer system reports the CCN provides to DHH and its agents are accurate, and that computer systems operate in an accurate and timely manner.

Staff trained and experienced in data processing and data reporting as required to provide necessary and timely reports to DHH.

3.1.1.8 Medical and Professional Support Staff

The CCN shall have medical and professional support staff sufficient to conduct daily business in an orderly manner including having member services staff directly available during business hours for member services consultation, as determined through management and medical reviews. The CCN shall maintain sufficient medical staff, available twenty-four hours a day, seven days a week (24/7), to handle emergency services and care inquiries. The CCN shall maintain sufficient medical and professional support staff during non-business hours, unless the CCN's computer system automatically approves all emergency services and claims relating to screening and treatment and support/education to promote implementation of patient-centered medical homes.

3.1.1.9 Utilization Management Staff

The CCN shall have sufficient utilization management staff, qualified by training, experience and certification/licensure to conduct the CCN's utilization management functions.

3.1.1.10 Case Management/Chronic Care Management Staff

The CCN shall have sufficient case management and chronic care management staff, qualified by training, experience and certification/licensure to conduct the CCN's case management and chronic care management functions.

CCN must have a compliance committee that is, along with the compliance officer, accountable to senior management (e.g. CCN Project Director). The compliance officer shall have effective lines of communication with all the CCN's employees and contractors. (See monitoring and reporting requirements within the *CCN-P Policy and Procedure Guide* and 42 CFR §438.608)

3.1.1.11 Medical Records Review Coordinator

The CCN shall have a designated person, qualified by training and experience, to ensure compliance with the medical records requirements as described in this Provider Agreement and *CCN-P Policy and Procedure Guide*. The Medical Records Review Coordinator shall maintain medical record standards and direct medical record reviews according to the terms of this Provider Agreement and *CCN-P Policy and Procedure Guide*.

3.1.1.12 Claims/Encounter Manager

The CCN shall have a designated person qualified by training and experience to oversee encounter data submittal and processing and to ensure the accuracy, timeliness and completeness of processing payment and reporting.

3.1.1.13 Member Education and Marketing Coordinator

The CCN shall have a designated person, qualified by training and experience, to ensure the CCN adheres to the Member Education and Marketing requirements of this Provider Agreement and *CCN-P Policy and Procedure Guide*.

3.1.1.14 Grievance System Coordinator and Staff

The CCN shall have a designated person, qualified by training and experience, to process and resolve complaints, grievances and appeals and be responsible for the CNN's grievance system.

The CCN shall have sufficient support staff (clerical and professional) to process grievances and appeals within the required time frames and to assist complainants in properly filing grievances;

3.1.1.15 Positions to be Housed in Louisiana

The following positions shall be housed in the State of Louisiana:

- a. Project Director
- b. Medical Director
- c. Clinical Services Coordinator
- d. Compliance Officer

3.1.1.16 Availability of Staff

All management staff must be available during DHH hours of operation and available for in-person meetings as requested by DHH.

3.1.2 Licensing Requirements

A CCN shall be: (1) a DHH certified health care organization which meets the Advanced Directive requirements as stated in 42 CFR §489, and (2) is licensed by the Louisiana Department of Insurance. All of the CCN's providers must be licensed and/or certified by the appropriate Louisiana licensing body or standard-setting agency, as applicable. All of the CCN's providers/contractors must comply with all applicable statutory and regulatory requirements of the Medicaid program and be eligible to participate in the Medicaid program. The CCN shall be responsible for assuring that all persons, whether employees, agents, contractors, or anyone acting for or on behalf of the CCN, are properly licensed at all times under applicable state law and/or regulations and are not suspended or excluded from participation in the Medicaid and/or Medicare program. All health professionals and health care facilities used in the delivery of services by or through the CCN shall be currently

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licensed to practice or operate in the state as required by state law and rules and regulations. The CCN shall ensure that none of its contractors have a Medicaid provider agreement with DHH that is terminated, suspended, denied, or not renewed as a result of any action of DHH, the CMS of the U.S. Department of Health and Human Services or the Medicaid Fraud Control Unit of the Office of the Louisiana Attorney General. Providers, who have been sanctioned by any state or federal controlling agency for Medicaid and/or Medicare fraud and abuse and are currently under suspension, shall not be allowed to participate in the Medicaid CCN Program.

Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for emergency services. Failure to adhere to this provision may result in one or more of the following sanctions:

3.1.2.1 DHH, at its sole discretion, may withhold part or all of the prepaid PMPM payment due on behalf of a CCN program member if service is provided or authorized by unlicensed personnel who should be licensed;

3.1.2.2 In the event DHH discovers that the CCN's contractor is not properly licensed by the appropriate authority, the CCN shall immediately remove the contractor from its provider list and the contractor shall discontinue providing services to Medicaid CCN members. Upon proper licensing by the appropriate authority and approval by DHH, the CCN may reinstate the contractor to provide services to Medicaid CCN members;

3.1.3 DHH may refer the matter to the appropriate licensing authority for action;

3.1.4. DHH may assess monetary penalties as described in **§13.3.1** or impose sanctions as described in **§13.3** of this Provider Agreement.

3.2 Credentiaing and Re-credentialing of Providers and Clinical Staff

The CCN must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12; §438.206, §438.214, §438.224 and §438.230 as well as the *CCN-P Policy and Procedure Guide* and NCQA Health Plan Accreditation Standards for credentialing and re-credentialing. These

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procedures shall be submitted for review and approval as specified in the CCN Enrollment Process (See *CCN-P Policy and Procedure Guide*).

3.2.1 The process for periodic re-credentialing shall be implemented at least once every three (3) years.

3.2.2 If the CCN is not NCQA Health Plan accredited and has delegated credentialing to a contractor, there shall be a written description of the delegation of credentialing activities within the contract. The CCN must require the contractor provide assurance that all licensed medical professionals are credentialed in accordance with DHH's credentialing requirements. DHH will have final approval of the delegated entity.

If the CCN has NCQA Health Plan Accreditation the credentialing policies and procedures policies shall meet DHH's credentialing requirements.

3.2.3 The CCN shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to assure compliance with this Provider Agreement.

3.2.4 The CCN shall develop and implement a mechanism, with DHH's approval, for reporting quality deficiencies which result in suspension or termination of a network provider/ contractor(s). This process shall be submitted for review and approval as specified in the CCN Enrollment Process (See *CCN-P Policy and Procedure Guide*).

3.2.5 The CCN shall develop and implement an appeal process, with DHH's approval, for sanctions, suspensions, and terminations imposed by the CCN against network provider/contractor(s).

3.3 Training

The CCN shall be responsible for training all of its employees and network providers and/or contractors, to ensure that they adhere to the CCN policies and procedures and Medicaid rules and regulations. The CCN shall be responsible for conducting ongoing training on Medicaid and CCN Program policies and distribution of policy updates to its network providers/contractors. DHH reserves the right to attend any and all training programs and seminars conducted by the CCN. The CCN shall provide DHH a list of any marketing

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training dates (See §7 Marketing and Outreach), time and location, at least fourteen (14) calendar days prior to the actual date of training.

3.4 Liaisons

The CCN shall designate an employee of its administrative staff to act as the liaison between the CCN and DHH for the duration of the Provider Agreement. DHH's Medicaid Coordinated Care Section will be CCN's point of contact and shall receive all inquiries and requests for interpretation regarding this Provider Agreement and all required reports unless otherwise specified in this Provider Agreement. The CCN shall also designate a member of its senior management who shall act as a liaison between the CCN's senior management and DHH when such communication is required. If different representatives are designated after approval of this Provider Agreement, notice of the new representative shall be provided in writing within five (5) business days of the designation.

3.5 Material Changes

The CCN shall notify DHH immediately of all material changes affecting the delivery of health care or the administration of services provided under this Provider Agreement, for example any impending problem the CCN is aware of such as breakdown of contract negotiations with an active provider/hospital that will materially impact the CCN's network access requirements. Material changes include, but are not limited to, changes in: composition of the provider network or contractor network that impacts network adequacy; CCN's complaint and grievance procedures; health care delivery systems or services, expanded services; benefits; geographic service area or payments; enrollment of a new population; procedures for obtaining access to or approval for health care services; and the CCN's ability to meet their declared maximum enrollment levels (upward or downward movement in originally specified maximum enrollment levels). Changes must be approved in writing by DHH at least thirty (30) days in advance of the proposed change implementation.

For those changes that were not within of the control the CCN, the CCN shall immediately notify DHH once it has knowledge of the change or impending change that will need to be made, but no later than, seven (7) calendar days of the change or knowledge of an impending change for approval. The CCN must provide documentation, with the approval request, of the events that caused the CCN to be unable to submit the change thirty (30) days in advance. DHH shall make the final determination as to whether the events were or were not within the control of the CCN.

The CCN must provide CCN members with a copy of all approved changes at least thirty (30) days prior to the intended effective date of the change. DHH shall make the final determination as to whether a change is material.

The CCN shall be responsible for all costs associated with any changes the CCN makes during the term of this Provider Agreement or during Provider Agreement termination. Costs associated with any changes may include, but are not limited to, costs incurred for name changes, for changes to the enhanced benefit file, for transitioning members from one provider to another during a transition or termination process, and costs incurred by the Enrollment Broker in updating its system and website to incorporate the changes.

3.6 Incentive Plans

3.6.1 In accordance with 42 CFR §422.208 and §422.210, the CCN may operate a Physician Incentive Plan but specific payment cannot be made directly or indirectly under a Physician Incentive Plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

3.6.2 The CCN's incentive plans for its network providers/contractors shall be in compliance with 42 CFR §§438.6(h), 422.208 and 422.210. (See *CCN-P Policy and Procedure Guide*) The CCN shall submit any information regarding incentives as may be required by DHH (see §3.6.3).

3.6.3 The CCN shall disclose to DHH the following:

- a. Services that are furnished by a physician/group that are covered by any incentive plan;
- b. Type of incentive arrangement, e.g. withhold, bonus, capitation;
- c. Percent of withhold or bonus (if applicable);
- d. Panel size, and if patients are pooled, the approved method used; and
- e. If the physician/group is at substantial financial risk, the entity must report proof the physician/group has adequate stop loss coverage, including amount and type of stop-loss.

3.6.4 The CCN shall provide information on its incentive plans to any Medicaid member upon request (this includes the right to adequate and timely information on the plan).

3.7 **Notification of Legal Action**

The CCN shall give DHH 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 CCN's ability to perform under this Provider Agreement with DHH.

3.8 **Fraud and Abuse Compliance Plan**

The CCN must have administrative and management policies and procedures, including a mandatory compliance plan, that are designed to prevent, reduce, detect, correct and report known or suspected fraud, abuse, and waste in accordance with the requirements specified in this Provider Agreement and *CCN-P Policy and Procedure Guide*. The CCN will submit its Fraud and Abuse Compliance Plan to DHH during the enrollment process for approval by DHH and annually thereafter. Requests for revision(s) to the Plan must be submitted to and approved by DHH at least thirty (30) days prior to implementation of such revision(s).

These policies and procedures must include the following:

- 3.8.1** Written policies, procedures; and standards of conduct that articulates the CCN's commitment to comply with all applicable federal and state standards and regulations;
- 3.8.2** The designation of a compliance officer and a compliance committee that is accountable to senior management and requirements for an adequately staffed compliance office;
- 3.8.3** Effective education for the compliance officer, the organization's employees, CCN providers and members about fraud and abuse and how to report it;
- 3.8.4** Effective lines of communication between the compliance officer and the CCN employees, contractors, providers and DHH and/or its designee;

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- 3.8.5 Enforcement of standards through well-publicized disciplinary guidelines (e.g. member/provider manuals, trainings, or newsletters, bulletins);
- 3.8.6 Provisions for internal monitoring and auditing of the CCN's providers, contractors, employees, and others;
- 3.8.7 Provision for prompt response to detected offenses and for development of corrective action initiatives relating to this Provider Agreement; and
- 3.8.8 Procedures for timely and consistent exchange of information and collaboration with DHH Program Integrity Unit, Attorney General Medicaid Fraud Control Unit (MFCU), and DHH contracted EQRO regarding suspected fraud and abuse occurrences.

These policies along with the designation of the compliance officer and committee must be submitted to DHH for approval during the CCN Enrollment Process and then thirty (30) days prior to whenever material changes occur.

The CCN must immediately report to DHH any suspicion or knowledge of fraud and abuse including, but not limited to, the false or fraudulent filings of claims and the acceptance of or failure to return, monies allowed to be paid on claims known to be fraudulent. See the *CCN-P Policy and Procedure Guide* for additional guidance.

3.9 Ownership

The CCN shall provide DHH with full and complete information on the identity of each person or corporation with an ownership or controlling interest (5%+) in the CCN, or any contractor in which the CCN has 5% or more ownership interest. The CCN shall also provide such required information including, but not limited to financial statements, for each person or entity with ownership or controlling interest of 5% or more in the CCN and any of its contractors, including all entities owned or controlled by a parent organization. This information shall be provided to DHH on the approved Disclosure Form and whenever changes in ownership occur.

3.10 Excluded Parties

The CCN shall be responsible for screening all providers, employees, and contractors through the Excluded Parties List Service administered by the

General Services Administration, initially and monthly thereafter, when it enrolls any provider or contractor, to ensure that it does not employ individuals who are debarred, suspended, or otherwise excluded from participating in Federal procurement activities and/or have an employment, consulting, or other agreement with debarred individuals for the provision of items and services that are significant to the CCN entity's Provider Agreement obligation. The CCN shall also report to DHH any network providers or contractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program.

3.11 Advance Directive

The CCN must maintain policy and procedures concerning advance directives with respect to all adult individuals receiving medical services by or through the CCN in accordance with 42 CFR §489.438.6(i)(1). The written information provided by the CCN must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

3.12 Prohibited Affiliations with Individuals Debarred by Federal Agencies. General Requirement

As per 42 CFR §438.610(a) and (b), a CCN may not knowingly have a relationship with the following:

- a. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549; or
- b. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1).

The relationship is described as follows:

- a. A director, officer, or partner of the CCN;
- b. A person with beneficial ownership of five (5) percent or more of the CCN's equity.
- c. A person with an employment, consulting or other arrangement with the CCN under its contract with the State.

3.13 Provider Discrimination Prohibition

In accordance with 42 CFR 438.12 and 214(c), a CCN may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. The CCN shall not discriminate against the participation, reimbursement, or indemnification of any provider who serves high-risk populations or specializes in conditions that require costly treatment. If the CCN declines to include individuals or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

In all contracts with health care professionals, a CCN must comply with the requirements specified in 42 CFR §438.214.

If a CCN declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. However 42 CFR 438.12 (a) may not be construed to:

- Require the CCN to contract with providers beyond the number necessary to meet the needs of its enrollee.
- Preclude the CCN from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or
- Preclude the CCN from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to enrollee.

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4 CORE BENEFITS AND SERVICES AND ACCESS STANDARDS

The CCN shall possess the expertise and resources to ensure the delivery of quality health care services to CCN members in accordance with the Medicaid program standards and the prevailing medical community standards. The CCN shall adopt practice guidelines that are:

- Based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- Take into account the needs of the members;
- Adopted in consultation with contracting health care professionals; and
- Reviewed and updated periodically as appropriate.

The CCN shall disseminate the practice guidelines to all affected providers and, upon request, to members and potential members.

When reimbursing for defined core benefits and services provided by an in-network provider, the CCN rate of reimbursement shall be no less than the Medicaid fee-for-service rate in effect on date of service at the time the services were performed, unless mutually agreed upon by the CCN and the provider.

4.1 Core Benefits and Services

Core benefits and services, as defined in Appendix B, shall be available through the CCN to each Medicaid member within the Coordinated Care Network - Prepaid. The CCN shall provide a mechanism to reduce inappropriate and duplicative use of health care services. Services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to eligibles under Medicaid fee-for-service as specified in 42 CFR §438.210(a)(1) and (2) and must meet the requirements set forth in this Provider Agreement and *CCN-P Policy and Procedure Guide*. The CCN:

- 4.1.1** Shall ensure that services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- 4.1.2** May not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the member;
- 4.1.3** May place appropriate limits on a service (a) on the basis of certain criteria, such as medical necessity; or (b) for the purpose of utilization

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control, provided the services furnished can reasonably be expected to achieve their purpose.

4.1.4 May exceed the limits as specified in the minimum FFS service requirements outlined in *CCN-P Policy and Procedure Guide*. No medical service limitation can be more restrictive than those that currently exist under the Title XIX Louisiana Medicaid State Plan.

4.1.5 In the provision of core benefits and services outlined and defined in this Provider Agreement and the *CCN-P Policy and Procedure Guide*, shall provide medically necessary and appropriate care to Medicaid CCN program members under this Provider Agreement.

See definition of “medically necessary services” in Appendix A. DHH shall make the final interpretation of any disputes about the medical necessity and continuation of core benefits and services under this Provider Agreement based on whether or not the Medicaid fee-for-service program would have provided the service.

4.1.6 If a CCN elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the CCN must furnish information about the services it does not cover in accordance with 1932(b)(3)(B)(ii) and 42 CFR §438.102(b)(1) by notifying:

- a. DHH with its PE 50 application or whenever it adopts the policy during the term of the Provider Agreement;
- b. The potential enrollees before and during enrollment in the CCN;
- c. Enrollees within ninety (90) days after adopting the policy with respect to any particular service; and
- d. Members through the inclusion of the information in the Member’s Manual.

4.1.7 Shall provide pregnancy-related services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of being pregnant and includes but is not limited to prenatal care, delivery, postpartum care, and family planning service for pregnant women in accordance with 42 CFR Part 440 Subpart B.

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4.1.8 Shall provide core benefits services to Medicaid/CHIP members. (See Appendix B for comprehensive listing of core benefits services):

- Inpatient Hospital Services*
- Outpatient Hospital Services
- Ancillary Medical Services
- Organ Transplant and Related Services
- Family Planning (not applicable to CCN operating under §1.9 of this Provider Agreement)
- EPSDT/Well Child Visits
- Emergency Medical Services
- Communicable Disease Services
- Durable Medical Equipment
- Emergency and Non-emergency Medical Transportation
- Home Health Services
- Basic Behavioral Health Services
- School-Based Health Clinic Services
- Physician Services
- Maternity Services
- Chiropractic Services
- Therapy Services (physical, occupational, speech and respiratory therapies)

*Transition Provision: In the event a member transitions from CCN included status to a CCN excluded status before being discharged from the hospital and/or rehab facility, the cost of the entire admission will be the responsibility of the CCN entity. This is only one example and does not represent all situations in which the CCN is responsible for cost of services during a transition.

The core benefits and services provided to the members shall include, but are not limited to, those services specified in Appendix B –Louisiana State Plan Services Table. **This table is not all inclusive.** Policy transmittals, State Plan amendments, regulations, provider bulletins, provider manuals, and fee schedules, issued by DHH are the final authority regarding services, and can be found in the Medicaid Library

4.2 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/ Well Child Visits

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is a comprehensive and preventive child health program for individuals under the

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age of 21. The EPSDT statute and federal Medicaid regulations require that states cover all services within the scope of the federal Medicaid program, including services outside the Medicaid State Plan, if necessary to correct or ameliorate a known medical condition. 42 U.S.C. § 1396d(r)(5). The program consists of two mutually supportive, operational components: (1) assuring the availability and accessibility of required healthcare services; and (2) helping Medicaid members and their parents or guardians effectively use these resources. The intent of the EPSDT program is to direct attention to the importance of preventive health services and early detection and treatment of identified problems.

The CCN shall have written procedures for EPSDT services in compliance with 42 CFR §441.50, Subpart B-Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), as well as be in compliance with the Centers for Medicare and Medicaid Services (CMS) State Medicaid Manual, Part 5 - EPSDT. These articles outline the requirements for EPSDT, including assurance that: all EPSDT eligible members are notified of EPSDT available services; that necessary screening, diagnostic, and treatment services are available and provided; and tracking or follow-up occurs to ensure all necessary services were provided to all of the CCN's eligible Medicaid children and young adults. The requirements for provision of EPSDT services are outlined in the *CCN-P Policy and Procedure Guide*.

DHH will provide the CCN with immunization data for Medicaid CCN members through the month of their twenty-first (21st) birthday, who are enrolled in the CCN. Refer to *CCN-P Policy and Procedure Guide*.

The CCN shall assure that all medically necessary Medicaid State Plan coverable diagnosis, treatment and screenings services are provided, either directly, through contracting, or by referral. The utilization of these services shall be reported as referenced in the *CCN-P Policy and Procedure Guide*. The CCN's providers shall also report the required immunization data into the Louisiana Immunization Network for Kids (LINKS) administered by the DHH/Office of Public Health. Expenditures for the medical services as previously described have been factored into the prepaid PMPM rate described in §2.1 of this Provider Agreement and the CCN will not receive any additional payments.

4.3 Emergency Medical Services

The CCN shall provide that emergency services be rendered without the requirement of prior authorization of any kind. The CCN shall advise all Medicaid CCN members of the provisions governing in and out-of-service area use of emergency services as defined in Appendix A. The CCN's protocol for

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provision of emergency services must specify the circumstances under which the emergency services will be covered when furnished by a provider with which the CCN does not have contractual or referral arrangements. The CCN shall make prompt payment for covered emergency services that are furnished by providers that have no arrangements with the CCN for the provision of such services. The attending emergency physician or the provider actually treating the member shall determine when the member is sufficiently stabilized for transfer or discharge.

The CCN shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. CCN shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's PCP, CCN, or applicable state entity of the member's screening and treatment within 10 calendar days of presentation for emergency services. The CCN shall not deny payment for treatment when a representative of the entity instructs the member to seek emergency services. The CCN shall not deny payment for treatment obtained when a member had an emergency medical condition and the absence of immediate medical attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of emergency medical condition.

4.3.1 The CCN shall be responsible for payment to providers in and out of the CCN provider network and service area, without requiring prior approval, for the following services and in accordance with the SSA Section 1867 (42 U.S.C. 1395 dd):

4.3.1.1 Determining if an emergency exists for Medicaid CCN members when the medical screening service is performed;

4.3.2.2 Treatment as may be required to stabilize the medical condition; and for

4.3.2.3 Transfer of the individual to another medical facility within SSA Section 1867 (42 U.S.C. 1395 dd) guidelines and other applicable state and federal regulations. CCN shall prior authorize any services performed after the provider, whether in- or out-of-network, has stabilized the patient. CCN shall cover services subsequent to stabilization that were:

4.3.2.3.1 Pre-approved by CCN;

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- 4.3.2.3.2 Were not pre-approved by CCN because CCN did not respond to the provider of post-stabilization care services' request for pre-approval within 1 hour after the request was made;
- 4.3.2.3.3 If CCN could not be contacted for pre-approval; or
- 4.3.2.3.4 If the CCN and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the CCN shall give the treating physician the opportunity to consult with a network physician and the treating physician may continue with the care of the member until a network physician is reached or one of the criteria of 42 CFR §422.113(c)(3) is met. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

In compliance with Section 6085 of the Deficit Reduction Act (DRA) of 2005, reimbursement by the CCN to out-of-network providers for the provision of emergency services shall be no more than what would be paid under Medicaid FFS by DHH.

4.3.2 As specified in 42 CFR §438.114(e) and 42 CFR §422.113(c)(2)(i), (ii) and (iii), the CCN is financially responsible (consistent with 42 CFR §422.214) for post-stabilization care services obtained within or outside the CCN that are:

- 4.3.2.1** Pre-approved by a network provider or other CCN organization representative; or
- 4.3.2.2** Not preapproved by a network provider or other entity representative, but:

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4.3.2.2.1 Administered to maintain the member's stabilized condition within one (1) hour of a request to the entity for pre-approval of further post-stabilization care services;

4.3.2.2.2 Administered to maintain, improve or resolve the member's stabilized condition if the CCN:

a. Does not respond to a request for pre-approval within 1 hour;

b. Cannot be contacted; or

c. CCN's representative and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the CCN must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of 422.133(c)(3) is met.

4.3.3 Expenditures for the medical services as previously described have been factored into the prepaid PMPM rate described in **§2.1** of this Provider Agreement and the CCN will not receive any additional payments. The CCN shall limit charges to members for any post-stabilization care services to an amount no greater than what the CCN would charge the member if he/she had obtained the services through one of the CCN's providers (as specified in 42 CFR §438.114(e) and 42 CFR §422.113(c)(2)(iv)).

4.3.4 The CCN's financial responsibility for post stabilization care services it has not pre-approved ends when:

- A network physician with privileges at the treating hospital assumes responsibility for the member's care;

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- A network physician assumes responsibility for the member's care through transfer;
- A representative of the CCN and the treating physician reach an agreement concerning the member's care; or
- The member is discharged.

4.4 Hysterectomies

The CCN shall cover the cost of medically necessary hysterectomies as provided in 42 CFR §441.255 (2005, as amended). CCN provided non-elective, medically necessary hysterectomies shall meet the requirements as outlined in the *CCN-P Policy and Procedure Guide*. Expenditures for the medical services as previously described have been factored into the prepaid PMPM rate described in § 2.1 of this Provider Agreement and the CCN will not receive any additional payments.

4.5 Sterilization

Sterilization is defined as any medical treatment or procedure that renders an individual permanently incapable of reproducing. Federal regulations contained in 42 CFR §§441.250 - 441.259 require that a consent form be completed before a sterilization procedure can be performed. Non-therapeutic sterilizations shall be documented with a completed Consent Form. Sterilization for a male or female must meet the requirements as outlined in the *CCN-P Policy and Procedure Guide*. Expenditures for the medical services as previously described have been factored into the prepaid PMPM rate described in § 2.1 of this Provider Agreement and the CCN will not receive any additional payments.

4.6 Limitations on Abortions

The CCN shall provide for abortions in accordance with 42 CFR §441. 200 et seq Subpart E and the requirements of the Hyde Amendment (Departments of Labor, Hospitals, Education, and Related Agencies Appropriations Act, 1998, Public Law 105-78, §§ 509 and 510) and only if:

- Physical disorder, injury, or illness including a life-endangering physical condition caused by or arising from the pregnancy itself would, as certified by a physician, place the mother in danger of death unless an abortion is performed; or

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- The pregnancy is the result of an act of rape or incest. Abortions must be prior approved before the service is rendered to ensure compliance with the Federal Regulation.

Abortions must be documented with a completed Abortion Statement Form and must meet the requirements as outlined in *CCN-P Policy and Procedure Guide* to satisfy state and federal regulations.

The CCN understands the CCN shall not make payment for any core benefit or service under this Provider Agreement to a network provider if any abortion performed hereunder violates federal regulations (Hyde Amendment).

4.7 Medical Services for Special Populations

The CCN shall identify members with special health care needs within ninety-(90) days of receiving the member's historical claims data (if available). Special health care needs population is defined as an individual of any age with a mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care requirements. However, during the phase-in implementation of the CCN Program, DHH will extend this requirement to one hundred and eighty (180) days from the enrollment effective date. The CCN shall adhere to the assessment and reporting requirements set forth in the *CCN-P Policy and Procedure Guide*.

4.8 School-Based Health Clinic Services

School-based health clinic (certified by the DHH Office of Public Health) services are those Medicaid services provided within school settings to Medicaid eligible children under the age of 21. The CCN shall not require referrals and shall be financially responsible for those medically necessary core benefits and services provided within the school settings; typically such services are provided by independent clinic providers. The CCN shall facilitate care coordination, case management and referrals between school-based providers and the CCNs' network providers. The CCN shall have written procedures for promptly transferring medical and developmental data needed for coordinating ongoing care with school-based services.

The CCN may stipulate that reimbursement will be contingent upon receiving a clean claim and all the medical records information required to update the member's medical records.

The CCN shall not be responsible for Individualized Education Plan (IEP) services or services provided by schools or their affiliates funded with certified

public expenditures (CPEs). IEP services and those funded with CPEs shall continue to be reimbursed fee-for-service.

4.9 Women, Infant, and Children (WIC) Program Referral

The CCN shall be responsible for ensuring that coordination exists between the WIC Program and CCN providers. Coordination shall include referral of potentially eligible women, infants and children and reporting of appropriate medical information to the WIC Program. The DHH Office of Public Health administers the WIC Program. A sample referral/release of information form is found in *CCN-P Policy and Procedure Guide*, WIC Referral Form.

4.10 Institutional Long-Term Care Facilities/Nursing Homes

The CCN is not responsible for any institutional long-term care facility/nursing home services. All such services shall continue to be reimbursed fee-for-service. Any CCN member transitioned to a nursing home level of care is eligible for disenrollment at the earliest effective date allowed by system edits and the CCN is responsible for notifying DHH of any CCN members **requiring institutionalization** in a long-term care facility/nursing home.

The CCN is responsible for all core benefits as long as a member is enrolled with the CCN, including periods in which the member is admitted to a long-term care facility/nursing home for rehabilitative purposes.

4.11 Behavioral Health Services

The CCN shall strongly support the integration of both physical and behavioral health services through screening and strengthening prevention/early intervention at the PCP level of care. The PCP shall collaborate with behavioral health specialists, including but not limited to, psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, mental health clinics, mental health rehabilitation service providers (public or private), and other specialty behavioral health providers, to ensure the provision of services to members as specified in the Medicaid State Plan.

4.11.1 For the purposes of this Provider Agreement, behavioral health services are divided into two levels:

4.11.1.1 Basic behavioral health services shall include, but not be limited to, screening, prevention, early intervention, medication management, and referral services as defined in the Medicaid State Plan; and

4.11.1.2 Specialized mental health services shall include, but not be limited to, services specifically defined in state plan and provided by a psychiatrist, psychologist, and/or mental health rehabilitation provider to those enrollees with a primary diagnosis of a mental and/or behavioral disorder.

4.11.2 Basic Behavioral Health Services

The CCN shall be responsible for providing basic behavioral health benefits and services to all members. The CCN shall utilize the screening tools and protocols approved by DHH. (See Section 8 of the *CCN-P Policy and Procedure Guide* for service delivery requirements.)

4.12 Family Planning Services

Family planning services are available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments and traditional contraceptive devices. The CCN family planning services shall also include services to members before and between pregnancies to optimize member health entering pregnancy. The CCN should agree to make available all family planning services to CCN members as specified in *CCN-P Policy and Procedure Guide*. CCN members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the CCN's provider network without any restrictions as specified in 42 CFR §431.51(b)(2). The out-of-network Medicaid enrolled family planning services provider shall bill the CCN and be reimbursed no less than the fee-for-service rate in effect on the date of service. CCN members should be encouraged by the CCN to receive family planning services through the CCN's network of providers to ensure continuity and coordination of a member's total care. No additional reimbursements shall be made to the CCN for CCN members who elect to receive family planning services outside the CCN's provider network.

4.13 Excluded Services

The excluded services set forth below will continue to be reimbursed by the Louisiana Medicaid program on a fee-for-service basis. The CCN's providers shall advise enrollees of the availability of excluded services and how to obtain excluded services as well as Refer to the *CCN-P Policy and Procedure Guide* for more detailed information on these services. The Department shall have the right to incorporate these services at a later date.

- Services provided through DHH's Early-Steps Program (IDEA Part C Program Services)

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

4.14 Expanded Services/Benefits

The CCN may offer expanded services and benefits to enrolled Medicaid CCN members in addition to those core benefits and services specified in *CCN-P Policy and Procedure Guide* of this Provider Agreement. These expanded services may include health care services which are currently non-covered services by the Title XIX Louisiana State Medicaid Plan and/or which are in excess of the amount, duration, and scope of those listed in the *CCN-P Policy and Procedure Guide*. These services/benefits shall be specifically defined by the CCN in regard to amount, duration and scope. DHH will not provide any additional reimbursement for these services/benefits. DHH will not provide or pay for member transportation to/from expanded services/benefits. Transportation for these services/benefits is the responsibility of the member and/or CCN, at the discretion of the CCN. The CCN shall provide DHH a description of the expanded services/benefits to be offered by the CCN for approval, and included in the CCN's marketing information. Additions, deletions or modifications to expanded services/benefits made during the Provider Agreement period must be submitted to DHH, for approval, in accordance with requirements listed in the *CCN-P Policy and Procedure Guide*.

4.15 Care Management

Care management is defined as the overall system of medical management encompassing, but not limited to, Utilization Management, Case Management, Care Coordination, Continuity of Care, Care Transition, Chronic Care Management, Quality Management, and Independent Review. The CCN shall ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating Medicaid covered services provided to the member. The CCN shall be responsible for ensuring:

- a. Member's health care needs and services/care are planned and coordinated through the CCN PCP;
- b. Accessibility of services and promoting prevention through qualified medical home practices in accordance with 42 CFR 438.6 (k) which requires the provision for reasonable and adequate hours of operation including 24 hour availability of information, referral, and treatment for emergency medical conditions; and
- c. Care coordination and referral activities incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical and/or behavioral health services.

4.15.1 Referral System

The CCN shall have a referral system for CCN members requiring specialty health care services to ensure that services can be furnished to enrollees promptly and without compromise to care. The CCN shall provide the coordination necessary for referral of CCN members to specialty providers. The CCN shall assist the member in determining the need for services outside the CCN network and refer the member to the appropriate service provider. The referral system must include processes to ensure monitoring and documentation of specialty health care and out-of-network referrals, services (e.g., medications prescribed, treatment received, recommendations for care), and follow up are included in the PCPs member medical record. Refer to the *CCN-P Policy and Procedure Guide* for services that are exempt from referral requirements. The CCN may request the assistance of DHH for the referral to the appropriate service setting. The CCN shall submit referral system processes and guidelines to DHH as specified in the CCN Enrollment Process (*See CCN-P Policy and Procedure Guide*), and annually thereafter, for approval.

4.15.2 Care Coordination, Continuity of Care, and Care Transition

The CCN shall develop and maintain effective care coordination, continuity of care, and care transition activities which ensure a continuum of care approach to providing health care services to CCN members. The CCN shall establish a process to coordinate the delivery of primary care services with services that are reimbursed fee-for-service by DHH. The CCN shall ensure member-appropriate PCP choice within the

CCN and interaction with providers outside the CCN. Continuity of care activities shall ensure that the appropriate personnel, including the PCP, are kept informed of the member's treatment needs, changes, progress or problems. Continuity of care activities shall provide processes by which CCN members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The CCN shall ensure that service delivery is properly monitored to identify and overcome barriers to primary and preventive care that a CCN member may encounter.

4.15.3 Utilization Management

The Network shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization. UM program policies and procedures shall meet all Utilization Review Accreditation Commission (URAC) or NCQA standards. Refer to the *CCN-P Policy and Procedure Guide* for UM Program requirements and service authorization exceptions. The Network shall submit UM policies and procedures to DHH as specified in the CCN Enrollment Process (*See CCN-P Policy and Procedure Guide*) for approval.

4.15.3.1 In accordance with 42 CFR § 438.210(b) the CCN shall:

- a. Have written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization member's request is for the provision of a service if a provider refuses a service or does not request a service in a timely manner;
- b. Have mechanisms to ensure consistent application of review criteria for authorizations decisions and consult with the requesting provider as appropriate;
- c. Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease; and

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- d. Provide a mechanism in which a member may submit, whether verbally or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures as per 42 CFR §431.201.

4.15.3.2

The CCN shall provide for the following decisions and notices:

- a. In regards to standard authorization decisions, the CCN shall provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if:
 - (i) The member, or the provider, requests extension; or
 - (ii) The CCN justifies to DHH upon request a need for additional information and how the extension is in the member's best interest.
- b. Expedited authorization decisions
 - (i) For cases in which a provider indicates, or the CCN determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CCN must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 3 working days after receipt of the request for service.
 - (ii) The CCN may extend the three (3) business day time period by up to fourteen (14) calendar days if the member requests an extension, or if the CCN justifies to DHH

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upon request a need for additional information and how the extension is in the member's best interest.

4.15.3.3 The CCN UM program shall utilize medical management criteria and practice guidelines that:

- a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- b. Consider the needs of the members;
- c. Are adopted in consultation with contracting health care professionals; and
- d. Are reviewed and updated periodically as appropriate.
- e. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply shall be consistent with the guidelines per 42 CFR §438.26(d).

The CCN shall disseminate the utilization management practice guidelines to all affected providers and members and potential members upon request.

4.15.3.4 In accordance with 42 CFR §§456.111 and 456.211, the Utilization Review plan must provide that each enrollee's record includes information needed for the UR committee to perform UR required under this section. This information must include, at least, the following:

- a. Identification of the enrollee
- b. The name of the enrollee's physician.
- c. Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission.

- d. The plan of care required under 42 CFR §456.70 and §456.172.
- e. Initial and subsequent continued stay review dates described under 42 CFR §§456.128, 456.133; 456.233 and 456.234.
- f. Date of operating room reservation, if applicable.
- g. Justification of emergency admission, if applicable.
- h. Reasons and plan for continued stay, if the attending physician believes continued stay is necessary.
- i. Other supporting material that the committee believes appropriate to be included in the record.

4.15.4 Case Management

The CCN shall develop and implement a case management program through a process which provides that appropriate and cost-effective medical services, medically-related services, social services, and basic behavioral health services are identified, planned, obtained and monitored for identified members who are high risk or have unique, chronic, or complex needs. The process shall integrate the member's and case manager's review of the member's strengths and needs resulting in a mutually agreed upon appropriate and cost-effective service plan that meets the medical, functional, social and behavioral health needs of the member. The case manager should assist/facilitate the discharge planning process when assistance is needed to ensure patients receive care deemed medically necessary by the treating physician. The CCN shall submit case management program policies and procedures to DHH for approval as specified in the CCN Enrollment Process (*See CCN-P Policy and Procedure Guide*) and annually thereafter.

4.15.5 Chronic Care Management Program (CCMP)

The CCN shall provide a Chronic Care Management Program (CCMP) as identified in the *CCN-P Policy and Procedure Guide* for members with chronic conditions. The Chronic Care Management Program shall:

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- a. Emphasize prevention of exacerbation and complication of chronic diseases utilizing evidence based clinical practice guidelines and patient empowerment and activation strategies;
- b. Encourage the evaluation of clinical, humanistic and economic outcomes;
- c. Address co-morbidities through a whole-person approach; and
- d. Promote chronic care management strategies, such as: referral processes; after hours protocols, and targeted management to focus on those in greatest need.

4.15.6 Quality Management

The CCN will establish and implement a Quality Assessment and Performance Improvement (QAPI) program as required by 42 CFR §§438.200-438.242, 42 CFR §438.249(a)(1) and as specified in the *CCN-P Policy and Procedure Guide*. The CCN shall submit its QAPI Quality Assessment Work plan as specified in the CCN Enrollment Process (*See CCN-P Policy and Procedure Guide*), and annually thereafter, for DHH review and approval. DHH must approve any material change to the plan prior to implementation of the revisions. The CCN shall have a process in place to evaluate the impact and effectiveness of its QAPI program. The full scope of QAPI program requirements are outlined in the *CCN-P Policy and Procedure Guide*.

The CCN is required to conduct performance improvement projects as specified in the *CCN-P Policy and Procedure Guide*.

The CCN will agree to an External Quality Review, review of Quality Assessment Committee meeting minutes and annual medical audits to ensure that it provides quality and accessible health care to CCN members, in accordance with standards contained in the *CCN-P Policy and Procedure Guide* and under the terms of this Provider Agreement. Such audits shall allow DHH or its duly authorized representative to review individual medical records, identify and collect management data, including but not limited to surveys and other information concerning the use of services and the reasons for member disenrollment.

It is agreed that the standards by which the CCN will be surveyed and evaluated will be at the sole discretion and approval of DHH. If deficiencies are identified, the CCN must formulate a Corrective Action

Plan (CAP) incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. DHH must prior approve the CAP and will monitor the CCN's progress in correcting the deficiencies. See *CCN-P Policy and Procedure Guide*.

The CCN must attain health plan accreditation by the National Committee for Quality Assurance (NCQA) or Utilization Review Accreditation Commission (URAC). If the CCN is not currently accredited by NCQA or URAC, the CCN must attain accreditation by meeting NCQA/URAC's accreditation standards. The CCN's application for accreditation must be submitted at the earliest point allowed by the organization. The CCN must provide DHH with a copy of all correspondence with NCQA/URAC regarding the application process and the accreditation requirements. Failure to obtain NCQA/URAC accreditation and to maintain the accreditation thereafter shall be considered a breach of this Provider Agreement and shall result in termination of this Provider Agreement. Achievement of provisional accreditation status shall require a CAP within thirty (30) calendar days of receipt of the Final Report from NCQA and may result in termination of this Provider Agreement.

4.15.6.1 Performance Measures

The CCN is required to collect and report clinical and administrative performance measure (PM) data, as specified by DHH and in accordance with the *Quality Companion Guide*. Performance measure data shall be submitted to DHH quarterly, annually and upon DHH request. The data shall demonstrate adherence to clinical practice guidelines and/or improvement in patient outcomes. The CCN shall have processes in place to monitor and self-report all performance measures. DHH will monitor the CCN's performance using Benchmark Performance and Improvement Performance data.

Starting year 2 of the measurement year, or as otherwise specified by DHH, a maximum of 2.5 % (0.25% for each of 10 specific Performance Measures) of the total PMPM payments may be assessed for those specified performance measures that fall below DHH's performance standard. (See Appendix C - Performance Measures)

4.15.6.2 Performance Improvement Projects

The CCN is required to have an ongoing program of Performance Improvement Projects (PIP) that focus on clinical and non-clinical performance measures as specified in 42 CFR §438.240. DHH, in consultation with CMS and other stakeholders, may require specific performance measures and topics for performance improvement projects. The CCN shall report the status and results of each PIP as specified in the *CCN-P Quality Performance Measurement Companion Guide*. The CCN's PIPs shall be designed to achieve, through ongoing measurements and interventions, significant improvement sustained over time that is expected to have a favorable effect on health outcomes and member satisfaction. Each PIP must involve the following:

- 4.15.6.2.1 Measurement of performance using objective quality indicators;
- 4.15.6.2.2 Implementation of system interventions to achieve improvement in quality;
- 4.15.6.2.3 Evaluation of the effectiveness of the interventions; and
- 4.15.6.2.4 Planning and initiation of activities for increasing or sustaining improvement.

PIPs must be completed in a reasonable time period so as to generally allow information on the success of the PIPs in the aggregate to produce new information on quality of care every year.

DHH may impose monetary penalties, sanctions and/or restrict enrollment pending attainment of acceptable quality of care. As specified in the *CCN-P Policy and Procedure Guide*, a fixed percentage of the total prepaid amount paid to the CCN during the performance measure measurement year will be assessed for specified measures that do not meet or exceed measurement goals.

4.15.7 Members with Special Needs

In accordance with 42 CFR 438.208(c)(2), the CCN shall submit policy and procedures for approval by DHH during Step 2 of the CCN Enrollment Process, after any material revision and annually thereafter, the mechanisms to assess each Medicaid/CHIP enrollee identified as having

special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. Per 42 CFR 438.240(b)(3) and (4), the CCN shall also have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs and to detect both underutilization and overutilization of services.

4.16 Communicable Disease Services

Communicable disease services are available to help control and prevent diseases such as tuberculosis (TB), sexually transmitted diseases (STD), and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) infection. The CCN shall make available communicable disease services to CCN members as specified in *CCN-P Policy and Procedure Guide*.

4.16.1 Prompt Reporting of Reportable Diseases, and Access to Clinical Records of Patients with Reportable Diseases

The CCN or its network providers shall comply with the Louisiana Administrative Code; Sanitary Code, Title 51, Part II, Chapter 1 and La. R.S. 40:4 et.seq. by reporting all cases of TB, STD and HIV/AIDS infection to the state public health agency within twenty-four (24) hours of notification by provider or from date of service.

4.16.2 Control and Prevention of Communicable Diseases

DHH Office of Public Health (OPH) is the state public health agency responsible for promoting and protecting the public's health and has the primary responsibility for the control and prevention of communicable diseases such as TB, STD, HIV/AIDS infection and vaccine preventable diseases.

The CCN and/or its network providers are responsible for clinical management, treatment and direct observed therapy in accordance with the Joint Statement of the American Thoracic Society, CDC, and the Infectious Disease Society of American on the Treatment of Tuberculosis, dated June 20, 2003/52(RR11);1-77.

4.16.3 Patient Confidentiality

The public state health agency will promote coordination of care with the goal of helping ensure patient confidentiality; notwithstanding this Provider Agreement, in compliance with applicable state and federal laws, for CCN members who choose diagnosis and treatment for TB, STD

and HIV/AIDS infection in the state public health clinics, information regarding their diagnosis and treatment will be provided to the CCN's primary care provider assigned to that member only with the written consent of the member, unless otherwise provided by law.

4.17 Manner of Service Delivery and Provision

In establishing and maintaining the service delivery network, the CCN must consider the following:

- The anticipated Medicaid enrollment;
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid/CHIP populations enrolled in the CCN;
- The number of network providers who are not accepting new Medicaid/CHIP patients;
- The geographic location of providers and Medicaid/CHIP members; considering distance and travel time, and means of transportation ordinarily used by Medicaid/CHIP members; and
- All providers shall be in compliance with Americans with Disabilities Act (ADA) requirements and provide and provide physical access for Medicaid/CHIP members with disabilities.

The CCN shall provide female members with direct access to a women's health specialist within the network for core benefits and services necessary to provide women's routine and preventive health care services. This is in addition to the members designated source of primary care if that source is not a women's health specialist.

The CCN shall provide a second opinion from a qualified health care professional within the CCN or arrange for the member to obtain one outside the CCN at no cost to the member.

If the CCN's network providers are unable to provide necessary services, specified under the Provider Agreement, to a particular member, the CCN shall adequately and timely cover these services out-of-network for the member. The Provider Agreement will require any out-of-network providers to coordinate with the CCN with respect to payment to ensure that there is no cost to the member. Same as if the services were furnished within the CCN.

4.17.1 Service Area

The CCN shall provide all medically necessary specified services within a designated service area; at a minimum, the designated service area shall include one entire parish. The CCN may serve more than one parish and multiple service areas may be included in a Provider Agreement. DHH will enter into one Provider Agreement with each CCN regardless of the number of service areas. Preference will be given in the automatic assignment process to CCNs whose service area includes all parishes within the region.

The initial implementation of the Prepaid Coordinated Care Networks will be phased in based on DHH's administrative region. The CCN shall be required to enter into a new or amend their existing (if a CCN Provider Agreement is already on file) Provider Agreement for each phase of implementation. See the *CCN-P Policy and Procedure Guide* for the Provider Agreement submission requirements.

The CCN shall attach a copy of and describe its designated service area in the format as specified in the *CCN-P Policy and Procedure Guide*. The attachment shall be incorporated herein as part of the Provider Agreement. Any changes to the CCN's service area must be approved by DHH sixty (60) calendar days prior to the effective date of the change.

4.17.2 Adequacy of Providers and Services

In accordance with 42 CFR 438.206(b)(1) the CCN shall establish and maintain a provider network and in-network (within the geographic service area and within the timely standards specified in this Provider Agreement and *CCN-P Policy and Procedure Guide*) referral providers in sufficient numbers, as determined by DHH, to ensure that all required state plan services are available and accessible in a timely manner within the CCN's service area in accordance with § 4 of this Provider Agreement and the *CCN-P Policy and Procedure Guide* and as approved by DHH. DHH is responsible for evaluation of the adequacy of the provider network for participation as a Louisiana Medicaid Coordinated Care Network.

4.17.2.1 The CCN shall provide supporting documentation, as per 42 CFR §438.207(c)(1), at the time of submission as specified in the CCN Enrollment Process (*See CCN-P Policy and Procedure Guide*) that demonstrates that it has the capacity to serve the CCN's declared maximum enrollment in its service area in accordance with DHH's standards for access outlined in the

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Provider Agreement and the *CCN-P Policy and Procedure Guide*. Per 42 CFR §438.207(b), the CCN must submit documentation in the format specified by DHH that demonstrates that it complies with the following requirements:

- 4.17.2.1.1** Offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of members for the service area;
 - 4.17.2.1.2** Maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of members in the service area;
 - 4.17.2.1.3** The locations of facilities, primary care providers and network providers must be sufficient in terms of geographic convenience to Medicaid/CHIP enrollees; and
 - 4.17.2.1.4** Provides the numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid core benefits and services.
- 4.17.2.2** DHH detailed standards, criteria and requirements for CCN submissions and ongoing review are located in the *CCN-P Policy and Procedure Guide*.
- 4.17.2.3** In accordance with 42 CFR 438.206(c)(I)(ii), services by network providers shall be provided in the same manner as those services are provided to commercial members or comparable to commercial health plans if the CCN does not provide health services to commercial members.. The services shall be as accessible to CCN members as they are for non-Medicaid/CHIP members residing in the same geographic service area. If a CCN has no commercial base for comparison, the CCN shall at a minimum meet the access standards specified in this Provider Agreement and the *CCN-P Policy and Procedure Guide*.
- 4.17.2.4** The CCN shall notify immediately DHH of any changes that materially and/or adversely affects its ability to make available all core benefits and services to enrollees in a

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timely manner in accordance with § 4 of this Provider Agreement as required in 42 CFR §38.207(c). The CCN shall also have procedures to address these changes. Material changes that are not prior approved by DHH and/or that may impair the CCN member's access to services will be considered as grounds for Provider Agreement sanctions including but not limited to termination. The CCN shall submit documentation assuring adequate capacity and services as specified in this Provider Agreement, and specifically as follows, but no less than frequently than:

- a. Changes to the composition of its provider network and/or contractors;
- b. Changes in services, benefits, geographic service or payments, or;
- c. Enrollment of a new population in the CCN.

4.17.2.5

In the event a CCN is found to be in violation of the requirements stated in this section, DHH reserves the right to implement the CCN Provider 120 Day Transition Plan or other sanctions, as described in the *CCN-P Policy and Procedure Guide*.

4.17.2.6

DHH may also, at its sole discretion, suspend any new enrollments in the CCN, including automatic assignments, in the affected parish(es) during the Transition Plan period or until the CCN has demonstrated that it will be able to maintain its services in their designated service area(s).

4.18 CCN's Provider Network Composition

The CCN is not required to contract with providers beyond the number necessary to meet the needs of its enrollees. The CCN may use different reimbursement amounts for different specialties or for different practitioners in the same specialty and may establish measures that are designed to maintain quality of services and control costs consistent with its responsibilities to enrollees.

The CCN will be required to maintain specific member-to-specialist provider ratios. The CCN shall provide adequate access, as determined by DHH, either through employment or contracting, to providers for Primary Care Provider (PCP) referrals, specialty services and/or ancillary medical services to ensure

that Medicaid State Plan services are available in accordance with § 4 of this Provider Agreement and the *CCN-P Policy and Procedure Guide*. The CCN network providers shall comply with all requirements set forth in this Provider Agreement and the *CCN-P Policy and Procedure Guide*.

4.18.1 Primary Care Providers (PCP)

A PCP in the CCN must be a provider who provides or arranges for the delivery of medical services, including case management, to assure that all services, which are found to be medically necessary, are made available in a timely manner as outlined in § 4 of this Provider Agreement. The PCP may practice in a solo or group setting or may practice in a clinic (i.e., Federally Qualified Health Center or Rural Health Clinic) or outpatient clinic. The CCN shall agree to provide at least one (1) full time equivalent (FTE) PCP per two thousand (2,000) CCN members. The CCN shall ensure each individual PCP shall not exceed a linkage of total of 2,000 Medicaid/CHIP eligibles (including CommunityCARE) across all CCNs in which the PCP may be a network provider and a DHH CommunityCARE program provider.

The CCN shall identify and report to the Enrollment Broker within seven (7) calendar days of any PCP approved to provide services under this Provider Agreement, who will not accept new patients or have reached capacity.

The PCP shall serve as the member's initial and most important point of interaction with the CCN's provider network. The PCP responsibilities shall include, but not be limited to:

- 4.18.1.1** Managing the medical and health care needs of members to assure that all medically necessary services are made available in a timely manner;
- 4.18.1.2** Monitoring and follow-up of care provided by other medical service providers for diagnosis and treatment, to include services available under Medicaid fee-for-service;
- 4.18.1.3** Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through Medicaid;

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- 4.18.1.4** Maintaining a medical record of all services rendered by the PCP and other referral providers; and
- 4.18.1.5** Providing case management services to include, but not be limited to, screening and assessment, development of plan of care to address risks and medical needs and other responsibilities as defined in the *CCN-P Policy and Procedure Guide*.
- 4.18.1.6** Coordinate the services the CCN furnishes to the enrollee with the services the enrollee receives from any other CCN.
- 4.18.1.7** Share with other CCNs serving the enrollee the results of its identification and assessment of any enrollee with special health care needs (as defined by the state) so that those activities need not be duplicated.
- 4.18.1.8** To ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information. CCNs must comply with these requirements if they meet the definition of health plan found at 160.103: group health plan; health insurance issuer; HMO; Medicaid programs; SCHIP program, any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care.

4.18.2 Specialty Providers

The specialty provider must comply with all applicable statutory and regulatory requirements of the Medicaid program; be eligible to participate in the Medicaid program; and be Board Certified or Admissible.

4.18.2.1. Specialty Provider responsibilities shall include at a minimum:

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- a. Providing consultation summaries or appropriate periodic progress notes to the member's primary care provider on a timely basis, following a referral or routinely scheduled consultative visit; and
- b. Notifying the member's primary care provider when scheduling a hospital admission or any other procedure requiring the primary care provider's approval.

4.18.3 Availability of Providers for Adults and Children

The CCN shall ensure the availability of Specialty Providers as appropriate for both adult and pediatric members. The CCN shall ensure access to appropriate service settings for members needing medically high risk perinatal care, including both prenatal and neonatal care, as per *CCN-P Policy and Procedure Guide*.

4.18.4 Other Ancillary Medical Service Providers

Ancillary medical service providers including, but not limited to, ambulance services, durable medical equipment, home health services, and X-Ray/laboratories must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations.

4.18.5 Hospital Providers

Hospital services providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in the *CCN-P Policy and Procedure Guide*.

4.19 Service Accessibility Standards

The CCN shall ensure access to health care services (distance traveled, waiting time, length of time to obtain an appointment, after-hour care) in accordance with the *CCN-P Policy and Procedure Guide* in the provision of services under this Provider Agreement. DHH will monitor the CCN's service accessibility. The CCN shall provide available, accessible and adequate numbers of institutional facilities, service locations, service sites, and professional, allied and para-medical personnel for the provision of core benefits and services, including all emergency services, on a 24-hour-a-day, 7-days-a week basis, and shall take corrective action if there is failure to comply by any provider. At a minimum, this shall include:

4.19.1 Twenty-Four (24) Hour Coverage

The CCN shall ensure that all emergency medical care is available on a twenty-four (24) hours a day, seven (7) days a week basis through its network providers, and shall maintain, twenty-four (24) hours per day, seven (7) days per week telephone coverage to instruct CCN members on where to receive emergency and urgent health care.

The CCN's network may elect to provide 24 hour coverage by direct access or through arrangement with a triage system. Any triage system arrangement must be prior approved by DHH.

4.19.2 Travel Time and Distance

The CCN shall comply with the following maximum travel distance requirements. Requests for exceptions must be submitted in writing to DHH for approval.

4.19.2.1 Access to Primary Care Providers

4.19.2.1.1 Travel distance for members living in rural parishes shall not exceed 30 miles; and

4.19.2.1.2 Travel distance for members living in urban parishes shall not exceed 20 miles.

4.19.2.2 Access to Hospitals

4.19.2.2.1 For urban areas, within thirty (30) miles of a member's residence; and

4.19.2.2.2 For rural areas, if the CCN is unable to enter into an agreement with a tertiary hospital(s) within thirty (30) miles of a member's residence, the CCN may request, in writing, an exception to this requirement.

4.19.2.3 Access to Specialists

4.19.2.3.1 Travel distance shall not exceed 60 miles for at least 75% of members; and

4.19.2.3.2 Travel distance shall not exceed 90 miles for all members.

4.19.2.4 Access to Lab and X-ray services

4.19.2.4.1 Travel distance shall not exceed 30 miles; and

4.19.2.4.2 For rural areas, exceptions for community standards shall be justified, documented and submitted to DHH for approval.

Services are generally considered accessible if they reflect usual practice and travel arrangements in the local area. Generally, this is within a thirty (30) mile radius from a member's residence. Exceptions may be made if the travel distance for medical care exceeds these requirements.

Other medical service providers participating in the CCN's coordinated care delivery system also must be geographically accessible to CCN members, as outlined in the *CCN-P Policy and Procedure Guide*.

4.19.3 Scheduling/Appointment Waiting Times

The CCN shall ensure that its network providers have an appointment system for core benefits and service and/or expanded services which are in accordance with prevailing medical community standards as specified below.

The CCN's network providers/contractors shall not use discriminatory practices with regard to members such as separate waiting rooms, separate appointment days, or preference to private pay patients.

4.19.3.1 Timely Access

The CCN shall ensure that medically necessary services are available on a timely basis, as follows:

- a. Emergent or emergency visits immediately upon presentation at the service delivery site;
- b. Urgent Care within twenty-four (24) hours;
- c. Non-urgent sick care within seventy-two (72) hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;
- d. Maternity Care:

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1. Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmark date the CCN mails the member's welcome packet:
 2. Within their first trimester within fourteen (14) days;
 3. Within the second trimester with seven (7) days;
 4. Within their third trimester with three (3) day;
 5. High risk pregnancies within three (3) days of identification of high risk by the CCN or maternity care provider, or immediately if an emergency exists;
 6. Initial appointment for enrollees who become pregnant shall be within forty-two (42) days;
- e. Routine, non-urgent, or preventative care visits within six (6) weeks;
 - f. Specialty care consultation within one (1) month of referral or as clinically indicated;
 - g. Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care or as clinically indicated; and
 - h. Follow-up visits in accordance with ER attending provider discharge instructions.

The CCN shall adhere to waiting time as specified in the *CCN-P Policy and Procedure Guide*.

4.20 Cultural Considerations

The CCN shall promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

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The CCN shall have written procedures for the provision of language interpretation and translation services for any member who needs such services, including, but not limited to, members with limited English Proficiency, at no cost to the member as specified in 42 CFR § 438.10 (c) (3), (4) and (5).

4.21 FQHC/RHC Clinic Services

The CCN shall make a good faith effort to execute a contract with Federally Qualified Health Centers (FQHC), and, where applicable, Rural Health Clinics (RHC). In the event an agreement cannot be reached and an entity does not participate in the CCN, the CCN shall maintain documentation detailing efforts which were made.

If an agreement cannot be reached with a FQHC/RHC, the CCN is not required to reimburse the FQHC/RHC except in the following cases:

- 4.21.1** Unless the medically necessary services are required to treat an emergency medical condition;
- 4.21.2** If there are no CCNs in a service area that provide in-network access to FQHCs, then all CCNs within the service area would be required to reimburse the PPS rate for medically necessary out-of-network services specified in the Provider Agreement; and
- 4.21.3** DHH has chosen to recognize FQHCs that are certified Office of Public Health school-based health clinics; therefore whether the FQHC/SBHC is within their network or not, the CCN shall reimburse the FQHC/SBHC the PPS rate, for all services provided in the "school setting". However, if the child had a separate visit to the FQHC/SBHC outside the "school setting", the CCN could deny payment as out-of-network. School setting is defined as the physical location in which the Office of Public Health has certified to deliver school based health clinic services.

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5 CONTRACT REQUIREMENTS

5.1 CCN Contract Responsibilities

The CCN shall provide or assure the provision of all core benefits and services specified in §4 of this Provider Agreement. The CCN may provide these services directly or may enter into contracts with providers who will provide services to the members in exchange for payment by the CCN for services rendered. Contracts are required with all providers of services unless otherwise approved by the Department. Any plan to delegate responsibilities of the CCN to a contractor shall be approved by the Department and a copy of all model contracts shall be submitted to DHH for approval during the CCN Enrollment Process and/or prior to execution.

5.1.1 As required by 42 CFR §438.6(1), §438.230(a) and § 438.230(b)(1),(2),(3) the CCN shall be responsible to oversee all contractors' performance and shall be held accountable for any function and responsibility that it delegates to any contractor, including, but not limited to:

- a. All contracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the contract;
- b. The CCN must evaluate the prospective contractor's ability to perform the activities to be delegated;
- c. The contract must require a written agreement between the CCN and the contractor that specifies the activities and report responsibilities delegated to the contractor; and provides for revoking delegation or imposing other sanctions if the contractor's performance is inadequate;
- d. The CCN shall monitor the contractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations; and
- e. The CCN shall identify deficiencies or areas for improvement, and take corrective action.

5.1.2 Model contracts for each CCN network provider shall be submitted in advance to DHH and specify that the contractor adhere to the Quality Assessment and Performance Improvement Program (QAPI) requirements specified by DHH in this Provider Agreement, *CCN-P*

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Policy and Procedure Guide, and *Quality Companion Guide*. The CCN shall submit to DHH for review and approval, prior to execution, any contract that is materially different from the model contract for that provider type. DHH shall have the right to review and approve any and all contracts entered into for the provision of any services under this Provider Agreement. The turnaround time for approval is expected to be thirty (30) days or less.

- 5.1.3** Notification of amendments or changes to any contract which, in accordance with §3.5 of this Provider Agreement, materially affects this Provider Agreement, shall be provided to DHH prior to the execution of the amendment in accordance with §1.7 of this Provider Agreement. The CCN shall not execute contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§ 1128 (42 U.S.C. 1320a-7) (2001, as amended) or 1156 (42 U.S.C. 1320 c-5) (2001, as amended) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. The CCN shall not enter into any relationship (See Appendix A - Definition of Terms) with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

In the event of non-renewal of a contractor's agreement, the CCN shall inform DHH of the intent to terminate any contract that may materially impact the provider's network and/or operations, as soon as possible, but no later than seven (7) calendar days prior to the effective date of termination of said contract.

If the CCN terminates a provider's contract for cause, the CCN shall provide immediate written notice to the provider. The CCN shall notify DHH of the termination as soon as possible, but, no later than seven (7) calendar days, of written notification of cancellation to the provider.

If termination is related to network access, the CCN shall include in the notification to DHH their plans to notify Medicaid/CHIP members of such change and strategy to ensure timely access to Medicaid/CHIP members with out-of-network providers. If termination is related to the CCN's operations, the notification shall include the CCN's plan how it will ensure there will be no stoppage or interruption of services to member or providers.

The CCN shall make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt

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of issuance of the termination notice, to each CCN member who received his or her primary care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(5).

5.2 Contract Requirements

All contracts executed by the CCN pursuant to this section shall, at a minimum, include the requirements listed below. No other terms or conditions agreed to by the CCN and contractor shall negate or supersede the following requirements. All contracts must:

- 5.2.1 Be in writing and signed by the CCN and contractor;
- 5.2.2 Specify the effective dates of the contract agreement;
- 5.2.3 Specify in the contract that the contract and its appendices contain all the terms and conditions agreed upon by the parties.
- 5.2.4 Require that no modification or change of any provision of the contract shall be made unless such modification is incorporated and attached as a written amendment to the contract and signed by the parties, however the CCN may provide amendments by written notification through CCN bulletins board, if mutually agreed to in terms of the contract and with prior notice to DHH;
- 5.2.5 Assure that the contractor shall not, without the prior approval of the CCN, enter into any subcontract or other agreement, for any of the work contemplated under the contract without approval of the CCN;
- 5.2.6 Specify that the services provided under the contract must be in accordance with the Louisiana Medicaid State Plan and require that the contractor shall provide these services to members through the last day that the contract is in effect. All final Medicaid benefit determinations are within the sole and exclusive authority of DHH or its designee;
- 5.2.7 Specify that the contractor may not refuse to provide medically necessary or core preventive benefits and services to CCN members specified under this Provider Agreement for non-medical reasons (except those services allowable under federal law for religious or moral objections);
- 5.2.8 Require that the contractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the contract 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;

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- 5.2.9** Specify the amount, duration and scope of services to be provided by the contractor and inform the provider of covered services under Louisiana Medicaid State Plan, including all specific provider requirements outlined in the Provider Agreement and/or CCN-P Policy and Procedure Guide.;
- 5.2.10** Provide that emergency services be rendered without the requirement of prior authorization of any kind;
- 5.2.11** Require that if the contractor performs laboratory services, the contractor must meet all applicable state requirements and 42 CFR §§493.1 and 493.3, and federal requirements;
- 5.2.12** 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 members pursuant to the agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Provider Agreement). 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 164.3524 as amended and subject to reasonable charges;
- 5.2.13** 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. Exception to this requirement shall include once in a lifetime events such as but not limited to appendectomy, etc. 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 (LRS 40:1299.96) requires physicians to retain their records for at least six (6) years. These minimum record keeping periods begin to run 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;
- 5.2.14** Provide that DHH, U.S. Department of Health and Human Services (HHS), CMS, Office of Inspector General Comptroller, State Legislative

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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 this Provider Agreement, 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;

- 5. 2.15 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;
- 5. 2.16 Specify that the contractor shall monitor and report the quality of services delivered under the agreement 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/contractor practices and/or the standards established by DHH or its designee;
- 5. 2.17 Require that the contractor comply with any corrective action plan initiated by the CCN and/or required by DHH;
- 5. 2.18 Provide for submission of all reports and clinical information required by the CCN, including but not limited to, HEDIS, EPSDT, etc.;
- 5. 2.19 Require safeguarding of information about CCN members according to applicable state and federal laws and regulations and as described in **§14.18** and **§14.25** and of this Provider Agreement;
- 5. 2.20 Provide the name and address of the official payee to whom payment shall be made;
- 5.2.21 Make full disclosure of the method and amount of compensation or other consideration to be received from the CCN;
- 5. 2.22 Provide for prompt submission of information needed to make payment;
- 5. 2.23 Provide that the CCN shall pay ninety percent (90%) of all clean claims of each provider type, within thirty (30) calendar days of the date of receipt. The CCN shall pay ninety-nine (99%) of all clean claims of each provider type, within ninety (90) calendar days of the date of receipt. The date of receipt is the date the CCN receives the claim, as indicated by its data stamp on the claim. The date of payment is the date of the

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check or other form of payment. The CCN and its providers may, by mutual agreement, establish an alternative payment schedule. Any alternative schedule must be stipulated in the contract;

- 5.2.24** Provide that contractors must submit all claims for payment no later than twelve (12) months from the date of service;
- 5.2.25** Specify that the contractor shall accept 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. Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served;
- 5.2.26** Specify that at all times during the term of the agreement, the contractor shall indemnify and hold DHH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Provider Agreement between DHH and the CCN, unless the contractor is a state agency. For contractors that are not state agencies, the indemnification may be accomplished by incorporating §14.22 of this Provider Agreement in its entirety in the contractor'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;
- 5.2.27** Require the contractor to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the CCN's members and the CCN under the agreement. The contractor shall provide such insurance coverage at all times during the agreement and upon execution of the contract agreement, and shall furnish the CCN with written verification of the existence of such coverage;
- 5.2.28** Specify that the contractor agrees to recognize and abide by all state and federal laws, regulations and guidelines applicable to the provision of services under the Coordinated Care Program;
- 5.2.29** Provide that the agreement incorporates by reference all applicable federal and state laws or regulations, and revisions of such laws or regulations shall automatically be incorporated into the agreement as they become effective. In the event that changes in the agreement as a result of revisions and applicable federal or state law materially affect the position of either party, the CCN and contractor agree to negotiate such further amendments as may be necessary to correct any inequities;

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- 5.2.30** Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the agreement termination date, or early termination of the agreement and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the agreement; 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;
- 5.2.31** Specify that the CCN and contractor recognize that in the event of termination of this Provider Agreement between the CCN and DHH for any of the reasons described in this Provider Agreement, 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 contractor's activities undertaken pursuant to the contractor agreement. The provision of such records shall be at no expense to DHH;
- 5.2.32** Provide that the CCN and contractor 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;
- 5.2.33** Include a conflict of interest clause as stated in **§14.29** of this Provider Agreement between the CCN and DHH;
- 5.2.34** Specify that the contractor must adhere to the Quality Assessment Performance Improvement and Utilization Management (UM) requirements as outlined in *CCN-P Policy and Procedure Guide*. The QAPI and UM Requirements shall be included as part of the contract between the CCN and the contractor;
- 5.2.35** Provide that all contractors 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 contractor's ability to perform under its contract with CNN to provide services under this Provider Agreement.;
- 5.2.36** Contain no provision which provides incentives, monetary or otherwise, for the withholding of medically necessary care. See *CCN-P Policy and Procedure Guide*, Incentive Plans;
- 5.2.37** Specify that the contractor shall not assign any of its duties and/or responsibilities under this Provider Agreement without the prior written consent of the CCN;

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- 5.2.38** Specify that hospital contracts shall require that the hospitals notify the CCN and DHH of the births when the mother is a member of the CCN. The CCN contract shall also specify that the hospital is responsible for completing the web-based DHH Request for Medicaid ID Number, including indicating whether the mother is a member of the CCN, and submitting the form electronically to DHH and ;
- 5.2.39** For any contract with an FQHC/RHC, the contract shall specify that the CCN's PMPM Rate will include an amount equal to the Prospective Payment System (PPS) rate for each visit historically included in the FFS system and the CCN will reimburse the FQHC/RHC clinics an amount equal to the PPS rate for each visit. Any bonus or incentive arrangements made to the FQHCs/RHCs associated with CCN members must also be specified to DHH. The contract shall specify that the CCN shall submit the name of each FQHC/RHC and the number of Medicaid encounters paid to each FQHC/RHC by month of services to DHH for State Plan required reconciliation purposes. This information shall be submitted in the format required by DHH as contained in the *CCN-P Policy and Procedure Guide*;
- 5.2.40** 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;
- 5.2.41** Provide that the CCN shall not make payment to a FQHC/RHC which is less than the level and amount of payment the FQHC/RHC would have been entitled to receive as reimbursement from the Louisiana Medicaid Program for a fee-for-service claim;

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- 5.2.42** Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the contractor 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 this agreement;
- 5.2.43** Contain no provision which restricts a network provider/ contractor from contracting with another CCN or other managed care entity;
- 5.2.44** Provide that all records originated or prepared in connection with the contractor's performance of its obligations under this Provider Agreement, 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 in Louisiana and safeguarded by the contractor in accordance with the terms and conditions of this Provider Agreement. The contract must further provide that the contractor 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 this Provider Agreement, and as further required by DHH, for a period of six (6) years from the expiration date of the Provider Agreement, including any Provider Agreement 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 five (5) year period, whichever is later. If the contractor stores records on microfilm or microfiche or other electronic means, the contractor 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;
- 5.2.45** Where the CCN has entered into capitated reimbursement arrangements with providers, 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;
- 5.2.46** Contracts with physicians shall not be reimbursed for less than the Medicaid fee-for-service rate in effect on date of service, unless mutually agreed to by both parties;
- 5.2.47** Provide that in accordance with 42 CFR §438.210(e) the compensation to the CCN or individuals that conduct utilization management activities is

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not structured so as to provide incentives for the individual or CCN to deny, limit, or discontinue medically necessary services to any member;

- 5.2.48** Contain that in accordance with 42 CFR §438.106(c) and 1932(b)(6) providers, contractors and subcontractors shall not bill members any amount greater than would be owed if the CCN provided the services directly;
- 5.2.49** Provide that contractors 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 (*Louisiana Register, Vol 30, No. 8*); and
- 5.2.50** Provide that contractors, as applicable, register all births through LEERS (Louisiana Electronic Event Registration System) administered by DHH/Vital Records Registry.
- 5.2.51** Provide that PCP's contract specify the maximum number of linkages the CCN may link to the PCP. The contract shall also stipulate that by signing the contract the PCP confirms that the total number of linkages the PCP specifies to the CCN, along with any and all linkages, the PCP may have through CommunityCARE and with other CCNs, in which they are enrolled, will not exceed 2,000 Medicaid/CHIP (including CommunityCARE members) lives. The contract may also include language that non-compliance with this provision may result in sanctions, including but not limited to, financial sanctions, transfer of members to another PCP within the CCN, and/or termination of the contract.
- 5.2.52** Contain language that the contractor shall adhere to all requirements set forth for CCN network providers in the Provider Agreement and *CCN-P Policy and Procedure Guide*; and either physically incorporating these document as appendices to the contract or include language in the contract the CCN shall furnished these documents to the provider upon request.

5.3 Subcontractor Requirements

The CCN must oversee and be accountable for any functions and responsibilities that it delegates to any subcontractor, including:

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- 5.3.1 All subcontracts must fulfill the requirements of 42 CFR § 438 that are appropriate to the service or activity delegated under the subcontract.
- 5.3.2 Each CCN must ensure that the entity evaluates the prospective subcontractor's ability to perform the activities to be delegated.
- 5.3.3 The CCN must require a written agreement between the entity and the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
- 5.3.4 The CCN must ensure that the entity monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.
- 5.3.5 The CCN must ensure that the entity identifies deficiencies or areas for improvement, the entity and the subcontractor must take corrective action.

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6 EDUCATION, SELECTION AND ENROLLMENT PROCESS

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

DHH contracts with an Enrollment Broker who is responsible for the CCN Program's enrollment and disenrollment process for all Medicaid/CHIP potential enrollees and enrollees. The Enrollment Broker shall be the primary contact for Medicaid/CHIP eligibles concerning the selection of a Coordinated Care Networks and shall assist the potential enrollee to become a member of a CCN. The Enrollment Broker shall be the **only authorized** entity other than DHH, to assist a Medicaid/CHIP eligible in any manner in the selection of a CCN and shall be responsible for notifying all CCN members of their enrollment and disenrollment rights and responsibilities within the timeframe specified in this section. The rights afforded to potential CCN members are detailed in *CCN-P Policy and Procedure Guide, Members' Bill of Rights*.

The CCN shall abide by all enrollment and disenrollment procedures as outlined in the *CCN-P Policy and Procedure Guide*.

In accordance with 42 CFR §438.10(b)(1), the Enrollment Broker and CCN shall provide all enrollment notices, informational materials and instructional materials relating to enrollees and potential enrollees or members in a manner and format that are in a style and reading level that will accommodate the reading skills of CCN Enrollees. In general the writing should be at no higher than a 6.9 level, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy. The text must be printed in at least ten-point font, preferably twelve-point font.

The CCN agrees it shall have the statewide capacity to enroll a minimum of twenty-five thousand (25,000) Medicaid/CHIP eligibles.

6.1 Enrollment Population

6.1.1 **Mandatory Populations 42 CFR §438.1(a)(5)(i)**

Medicaid/CHIP groups mandated to participate in a Coordinated Care Network (CCN) include:

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

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- **LIFC Program** (Low Income Families with Children) - Individuals and families who meet the eligibility requirements of the AFDC State Plan in effect on July 16, 1996;
- **FITAP Program** (Families in Temporary Need of Assistance) - Individuals and families receiving cash assistance through the state's Temporary Assistance to Needy Families (TANF) Program administered by the DSS;
- **CHAMP-Child Program** - Children up to age 19, who meet financial and non-financial eligibility criteria. Deprivation or uninsured status is not an eligibility requirement;
- **Deemed Eligible Child Program** - Infants born to Medicaid eligible pregnant women, regardless of whether or not the infant remains with the birth mother, throughout the infant's first year of life;
- **Youth Aging Out of Foster Care** - Children under age 21 who were in foster care (and already covered by Medicaid) on their 18th birthday, but have aged out of foster care;
- **Continued Medicaid Program** - Short-term coverage for families who lose LIFC or TANF eligibility because of child support collections, an increase in earnings, or an increase in the hours of employment; and
- **Regular Medically Needy Program** - Individuals and families who have more income than is allowed for regular on-going Medicaid.
- **LaCHIP Program** - Children enrolled in the Title XXI Medicaid expansion program for low-income children under age 19 who do not otherwise qualify for Medicaid, including LaCHIP Phases I, II, and III.
- **Parents** eligible under Section 1931 and optional caretaker relative groups including:
 - LIFC Program

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- FITAP Program
- Continued Medicaid Program
- Regular Medically Needy Program
- **Pregnant Women** - Individuals whose basis of eligibility is pregnancy, who are eligible **only** for pregnancy related services {42 CFR§ 440.210(2)} including:
 - **LaMOMS (CHAMP-Pregnant Women)** - Pregnant women who receive coverage for prenatal care, delivery, and care sixty (60) days after delivery and
 - **LaCHIP Phase IV Program** - Non-citizen, uninsured pregnant women who receive prenatal care (from conception to birth) services.
- **Breast and Cervical Cancer (BCC) Program** - Uninsured women under age 65 who are not otherwise eligible for Medicaid and are identified through the Centers for Disease Control (CDC) National Breast and Cervical Cancer Early Detection Program as being in need of treatment for breast and/or cervical cancer, including pre-cancerous conditions and early stage cancer.
- **Aged, Blind & Disabled Adults** - Individuals, 19 or older, who do not meet any of the conditions for exclusion from participation in a CCN, including:
 - **Supplemental Security Income (SSI) Program** - Individuals 19 and older who receive cash payments under Title XVI (Supplemental Security Income) administered by the Social Security Administration and
 - **Extended Medicaid Programs** - Certain individuals who lose SSI eligibility because of a Social Security cost of living adjustment (COLA) or in some cases entitlement to or an increase in Retirement, Survivors, Disability Insurance (RSDI) benefits, i.e., Social Security benefits. SSI income standards are used in combination with budgeting rules which allow the exclusion of cost of

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living adjustments and/or certain benefits. Extended Medicaid consists of the following programs:

- **Disabled Adult Children** - Individuals over 19 who become blind or disabled before age 22 and lost SSI eligibility on or before July 1, 1987, as a result of entitlement to or increase in RSDI Child Insurance Benefits;
- **Disabled Widows/Widowers** - Disabled widows/widowers who would be eligible for SSI had there been no elimination of the reduction factor and no subsequent COLAs;
- **Early Widows/Widowers** - Individuals who lose SSI eligibility because of receipt of RSDI early widow/widowers benefits;
- **Pickle** - Aged, blind, and disabled persons who become ineligible for SSI or MSS as the result of cost of living increase in RSDI or receipt and/or increase of other income including:
 - **Group One** - Individuals who concurrently received and were eligible to receive both SSI and RSDI in at least one month since April 1, 1977, and lost SSI as the direct result of an RSDI COLA and
 - **Group Two** - Individuals who were concurrently eligible for and received both SSI and RSDI in at least one month since April 1, 1977, and lost SSI due to receipt and/or increase of income other than an RSDI COLA, and would again be eligible for SSI except for COLAs received since the loss of SSI;
- **Disabled Widows/Widowers and Disabled Surviving Divorced Spouses Unable To Perform Any Substantial Gainful Activity**-Widow/widowers who are not entitled to Part A Medicare who become ineligible for SSI due to receipt of SSA Disabled Widow/widowers Benefits so long as they were receiving SSI for the month prior to the month they began receiving RSDI, and they would continue to be eligible for SSI if the amount of the RSDI benefit were not counted as income;
- **Blood Product Litigation Program** - Individuals who lose SSI eligibility because of settlement payments under the Susan Walker

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v. Bayer Corporation settlement and the Ricky Ray Hemophilia Relief Fund Act of 1998;

- **Medicaid Purchase Plan Program** - Working individuals between ages 16 and 65 who have a disability that meets Social Security standards; and
- **Disability Medicaid Program** - Disabled and aged (65 or older) individuals who meet all eligibility requirements of the SSI program without first having a SSI determination made by the Social Security Administration.

6.1.2 Voluntary Populations

In accordance with 42 CFR § 438.6(d)(2) and for the purposes of participation in a CCN is voluntary for children under the age of 19 who receive Supplemental Security Income (SSI). After a choice period, potential enrollees under age 19 who receive in the disability category s will be enrolled in a CCN if they have not made a choice.

6.1.2.1 The following populations are also voluntary under the State's 1932 SPA and after a choice period of fifteen (15) days if they do not choose a plan, they will be enrolled in a CCN, but may request disenrollment at any time without cause, effective the first day following the month of the request for disenrollment including:

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

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

6.1.2.1.2 Children under 19 years of age who are:

- a. Eligible for SSI under title XVI;
- b. Eligible under section 1902(e)(3) of the Act;
- c. In foster care or other out-of-home placement;
- d. Receiving foster care or adoption assistance;

- e. Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the DHH in terms of either program participation or special health care needs; or
- f. Enrolled in the Family Opportunity Act Medicaid Buy-In Program.

Potential enrollees and enrollees may request an additional fifteen (15) day extension to the choice period if the request is made to the Enrollment Broker prior to the fifteenth (15th) day. The enrollment broker will ensure that all voluntary populations will be notified at the time of enrollment of their ability to opt out at any time without stating a cause.

6.1.3 Excluded Populations

Medicaid/CHIP eligibles who cannot voluntarily enroll with a CCN including:

- Individuals receiving hospice services;
- Individuals Residing in Nursing Facilities (NF) or Intermediate Care Facilities for the Developmentally Disabled (ICF/DD);
- Individuals with Medicare dual eligibles:
- Individuals who have been diagnosed with tuberculosis, or suspected of having tuberculosis, and receiving tuberculosis-related services through the Tuberculosis Infected Individual Program;
- Individuals receiving services through any 1915(c) Home and Community-Based Waiver including, but not limited to:
 - **Adult Day Health Care (ADHC)** - Direct care in a licensed adult day health care facility for those individuals who would otherwise require nursing facility services;
 - **New Opportunities Waiver (NOW)** - Individuals who would otherwise require ICF/DD services;

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- **Elderly and Disabled Adult (EDA)** - Services to persons aged 65 and older or disabled adults who would otherwise require nursing facility services;
- **Children's Choice (CC)** - Supplemental support services to disabled children under age 18 on the NOW waiver registry;
- **Residential Options Waiver (ROW)** - Individuals living in the community who would otherwise require ICF/DD services;
- **Supports Waiver** - Individuals 18 years and older with mental retardation or a developmental disability which manifested prior to age 22; and
- **Other HCBS waivers as may be approved by CMS.**
- Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the Office for Citizens with Developmental Disabilities' Request for Services Registry, also known as *Chisholm Class Members*;
- Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE), a community-based alternative to placement in a nursing facility that includes a complete "managed care" type benefit combining medical, social and long-term care services;
- Individuals with a limited eligibility period including:
 - **Spend-down Medically Needy Program** - An individual or family who has income in excess of the prescribed income standard can reduce excess income by incurring medical and/or remedial care expenses to establish a temporary period of Medicaid coverage (up to three months); and
 - **Emergency Services Only** - Emergency services for aliens who do not meet Medicaid citizenship/ 5-year residency requirements;
- Individuals enrolled in the LaCHIP Affordable Plan Program (LaCHIP Phase V) that provides benchmark coverage with a

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premium to **uninsured** low-income children under age 19 who do not otherwise qualify for Medicaid or other LaCHIP programs and

- Individuals enrolled in and receiving Family Planning services only in the Take Charge Program which provides family planning services to **uninsured** women ages 19 - 44 who are not otherwise eligible for any another Medicaid program.

6.2 Enrolling Medicaid/CHIP Eligibles in the CCN

6.2.1 The Enrollment Broker will inform the Medicaid/CHIP potential enrollee of all CCNs available in their geographic area. The Enrollment Broker shall comply with the information requirements of 42 CFR §438.10 to ensure that, before enrolling, the potential enrollee receives, from the Broker, the accurate oral and written information he or she needs to make an informed decision. This information shall be provided in accordance with Social Security Act 1932 and 42 CFR §438.104; in an objective, non-biased fashion that neither favors nor discriminates against any CCN or health care provider. The importance of early selection of a CCN shall be stressed, especially if the Medicaid/CHIP potential enrollee indicates priority health needs. To assist Medicaid/CHIP potential enrollees in identifying participating providers for each CCN, the Enrollment Broker will maintain and update weekly an electronic provider directory that is accessible through the Internet and will make available, (by mail) paper provider directories.

6.2.2 The Enrollment Broker shall assist the Medicaid/CHIP potential enrollee with the selection of a CCN that meets the potential enrollee's needs by explaining in a non-biased manner the criteria that may be considered when selecting a CCN. Medicaid/CHIP potential enrollees who are eligible for the CCN Program will have fifteen (15) calendar days from the postmark date that an enrollment form is sent to them by the Enrollment Broker to select a CCN. All members of a family unit will be required to select the same CCN unless extenuating circumstances warrant a different CCN. Such instances must be approved by DHH.

6.2.3 The CCN shall have written policies and procedures for notifying new members within ten (10) business days after receiving notification from the Enrollment Broker of enrollment. This notification must be in writing and include a listing of primary care providers' name, location, and office telephone numbers that the enrollee may choose as their primary care provider.

- 6.2.4 The CCN shall not discriminate against CCN members on the basis of their health history, health status, need for health care services or adverse change in health status; or on the basis of age, religious belief, sex/gender, or sexual orientation. This applies to enrollment, re-enrollment or disenrollment from the CCN. The CCN shall provide services to all eligible CCN members who enroll in the CCN.
- 6.2.5 The CCN may not restrict choice of the provider from whom the person may receive family planning services and supplies.
- 6.2.6 The Enrollment Broker's automatic assignment methodology shall take into consideration factors, such as, but not limited to:
- Potential enrollee's geographic parish of residence;
 - CCN geographic services area (preference will be given to CCNs with a service area that includes all parishes within the region)
 - Provider capacity;
 - Previous linkage with a CommunityCARE PCP (at transition from CommunityCARE to CCN);
 - Quality Indicators (when available); and
 - Provider practice restrictions/limits.

6.3 Enrollment Period

The CCN members shall be enrolled for a period of twelve (12) months contingent upon their continued Medicaid/CHIP eligibility. The member may request disenrollment, without cause, at any time during the ninety (90) days following the date of the member's initial enrollment or re-enrollment with the CCN. See §6.7 for procedures for disenrollment.

Annually, the Enrollment Broker will mail a re-enrollment offer to the CCN members to determine if they wish to continue to be enrolled with the CCN. Unless the member becomes ineligible for the CCN Program or provides written, oral or electronic notification that they no longer wish to be enrolled in the CCN, the member will remain enrolled with the CCN.

A CCN member who becomes disenrolled due to loss of Medicaid/CHIP eligibility but regains Medicaid/CHIP eligibility within sixty (60) calendar days will be automatically enrolled in the CCN which the member was previously associated with. Depending on the date eligibility is regained; there may be a gap on the member's CCN coverage. If Medicaid eligibility is regained after sixty (60) days, the reinstatement of Medicaid eligibility will prompt DHH's

Enrollment Broker to mail an enrollment packet to the Medicaid/CHIP potential enrollee. The Medicaid/CHIP potential enrollee may also initiate the re-enrollment process without an enrollment packet. See §6.7 for additional information on re-enrollment and the *CCN-P Policy and Procedure Guide* – Re-enrollment Section.

6.4 Selection or Assignment of a Primary Care Provider (PCP)

The CCN shall have written policies and procedures for handling the assignment of its members to a primary care provider. The CCN is responsible for linking all Medicaid/CHIP enrollees to a primary care provider. The CCN shall be responsible for providing to the Enrollment Broker, information on the capacity of each individual PCP on a quarterly basis.

If the member does not select a PCP and is auto assigned to a PCP by the CCN, the CCN shall allow the member to change PCP, at least once, during the first ninety (90) days from assignment to the PCP. After the ninety-first (91st) day, the member may be locked into the assignment to the selected PCP for a period of up to twelve (12) months beginning from the original date the member was assigned to the CCN.

If a member requests to change his or her primary care provider with cause, at any time during the enrollment period, the CCN must agree to grant the request to the extent reasonable and practical.

6.5 Enrollment of Newborns

The CCN shall be responsible for reporting births of newborns for enrolled members using DHH's web-based Request for Newborn ID system. (See *CCN-P Policy and Procedure Guide*) Newborns of Medicaid eligible mothers who were enrolled at the time of the newborn's birth will be automatically enrolled with the mother's CCN, retroactive to the month of the birth.

If there is an administrative lag in enrolling the newborn and costs are incurred during that period, the member shall be held harmless for those costs and the CCN shall pay for these services.

The CCN and its providers shall be required to register all births through LEERS (Louisiana Electronic Event Registration System) administered by DHH/Vital Records Registry.

6.6 CCN Follow Up of Voluntary Disenrollees

The CCN may conduct an initial follow up for all voluntary disenrollees. These members will be identified on the member listing file with a special indicator. The Enrollment Broker will provide the CCN with a member listing file (enrollments and disenrollments). The CCN may contact the member upon receipt of the member listing file. However, follow up must be within the guidelines outlined in *CCN-P Policy and Procedure Guide, Member Education and Enrollment Sections*.

6.7 Member Initiated Disenrollment and Change of CCN

A member shall remain in the CCN unless the member submits a written, electronic or oral request to disenroll, transfer to another CCN for cause or the member becomes ineligible for Medicaid and/or CCN enrollment. The member may disenroll from the CCN by:

- Requesting disenrollment, without cause, at any time during the ninety (90) days following the date of the member's initial enrollment or re-enrollment with the CCN;
- Requesting disenrollment, with cause, after the first 90 days through a written, electronic or oral request to disenroll. or transfer to another CCN; or
- Becoming ineligible for Medicaid/CHIP and/or CCN enrollment.

Oral requests to disenroll shall be confirmed by the Enrollment Broker by return call with written documentation, or in writing to the requestor. If a member's request to disenroll is not acted on within sixty (60) days, the request for disenrollment shall be considered approved.

A member who is a voluntary enrollee may request disenrollment from a CCN without cause at any time.

A member who is a mandatory enrollee may request disenrollment from the CCN as follows:

- For cause, at any time: The following are considered cause for disenrollment by the member:
 - The member moves out of the CCN's service area;

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- The CCN does not, because of moral or religious objections, cover the service the member seeks;
 - The member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the CCN's network of providers; and the member's PCP or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk; and
 - Other reasons, including but not limited to, poor quality of care, lack of access to services specified under the Provider Agreement, or lack of access to providers experienced in dealing with the member's health care needs.
- Without cause, at the following times:
 - During the ninety (90) days following the date of the member's initial enrollment with the CCN or the date the Enrollment Broker sends the member notice of the enrollment, whichever is later;
 - At least once a year during the annual open enrollment period thereafter;
 - Upon automatic reenrollment under 42 CFR §438.56(g), if a temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or
 - If DHH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a)(3).
 - For an enrollee of a rural single CCN under 42 CFR §438.52(b)(2) or (3), any limitation the CCN imposes on the CCN enrollee's freedom to change between primary care providers may be no more restrictive than the limitation on disenrollment under 42 CFR §438.56(c).

All member initiated disenrollment requests must be made to DHH's Enrollment Broker and the CCN shall refer all such requests that they receive to the Enrollment Broker. The CCN shall not approve or disapprove any request for disenrollment.

A member's request to disenroll must be acted on no later than the first day of the second month following the month in which the member filed the request. If not, the request shall be considered approved. If denied, as per 42 CFR §438.56(f)(2), the member may access the State Fair Hearing process outlined in § 9.7.5 of this Provider Agreement.

6.7.1 Member Choice Period

A member may request disenrollment, without cause, at any time during the ninety (90) days following the date of the member's initial enrollment with the CCN; at least once every twelve (12) month during open enrollment; or upon automatic reenrollment if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity. The request must be made to DHH's Enrollment Broker and may be verbal, written or electronic.

6.7.2 Member Disenrollment for Cause

A member in a CCN who is a mandatory enrollee and subject to the CCN "lock-in" period may initiate disenrollment or transfer after the first ninety (90) days of enrollment for **cause at any time**.

The following are cause for disenrollment:

- The member moves out of the CCN's service area;
- The CCN does not, because of moral or religious objections, cover the service the member seeks;
- The member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the CCN; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk;
- The Provider Agreement between the CCN and DHH is terminated;
- The member loses Medicaid eligibility;
- The member is placed in a nursing facility or intermediate care facility for the developmentally disabled;
- The member changes to an excluded group;

- To implement the decision of a hearing officer in an appeal proceeding by the member against the CCN or as ordered by a court of law; and/or
- Other reasons, including but not limited to:
 - Poor quality of care;
 - Lack of access to services provided under the Provider Agreement; and/or
 - Lack of access to providers experienced in dealing with the member's health care needs.

6.8 CCN Initiated Member Disenrollment

The CCN may request disenrollment of a member with a written request to DHH providing the member's name, Medicaid ID number, and detailed reasons for requesting the reassignment of the member. The CCN shall not request disenrollment for reasons other than those permitted under this Provider Agreement and/or in accordance with Louisiana Medicaid State Plan, rules, regulations and policy and procedures.

With proper documentation, the following are acceptable reasons for which the CCN may submit involuntary disenrollment requests to DHH's Enrollment Broker:

- Fraudulent use of the CCN's ID card. In such cases the CCN shall report the event to the Medicaid Program Integrity Section.
- The member's behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the CCN seriously impairs the organization's ability to furnish services to either the member or other members and such behavior is not linked to the member's diagnosis.
 - The CCN shall promptly submit such disenrollment requests to DHH. In no event shall the CCN submit a disenrollment request at such a date as would cause the disenrollment to be effective earlier than forty-five (45) calendar days after the occurrence of the event prompting the request for involuntary disenrollment.

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The CCN shall ensure that involuntary disenrollment documents are maintained in an identifiable member record.

- All requests will be reviewed on a case-by-case basis and subject to the sole discretion of DHH. All decisions are final and not subject to CCN dispute or appeal.

The CCN may not request disenrollment because of a member's:

- Health diagnosis;
- Adverse change in health status;
- Utilization of medical services;
- Diminished mental capacity;
- Pre-existing medical condition;
- Refusal of medical care or diagnostic testing;
- Uncooperative or disruptive behavior resulting from his or her special needs, unless it seriously impairs the CCN's ability to furnish services to either this particular member or other members as defined in this subsection;
- Attempt to exercise rights under the CCN's grievance system; or
- Request of one (1) PCP to have a member assigned to a different provider out of the CCN.

The CCN shall not attempt to discourage enrollment of prospective members or encourage disenrollment from the CCN of current members. DHH considers this a material violation and the CCN will be subject to intermediate sanctions.

Disenrollment shall be assisted and completed by the Enrollment Broker and in a manner so designated by DHH.

When the CCN requests an involuntary disenrollment, it shall notify the member in writing that the CCN is requesting a disenrollment, the reason for the disenrollment request, and an explanation that the CCN is requesting that the member be disenrolled in the next month, or earlier if necessary. Until the CCN

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receives written approval for involuntary disenrollment from DHH, the CCN shall continue services to the enrollee.

DHH will determine if the CCN has shown good cause to disenroll the member and DHH will give written notification to the CCN and the member of its decision. The member shall have the right to appeal any adverse decision.

If the CCN ceases participation in the Medicaid/CHIP enrollee's service area or ceases participation in the CCN Program, the CCN shall notify DHH in accordance with the termination procedures in §13.3.5.8 of this Provider Agreement. DHH will notify CCN program members and offer them the choice of another CCN, if there is CCN with capacity in their service area. If there are no other CCN options, they will be placed in fee-for-service. The CCN shall assist DHH in transitioning CCN members to another CCN or to the Medicaid fee-for-service delivery system to ensure access to needed health care services.

6.9 DHH Initiated Member Disenrollment

The Enrollment Broker will notify the CCN of the member's disenrollment due to the following reasons:

- Loss of Medicaid eligibility or loss of CCN mandatory or voluntary status;
- Death of a Member;
- Member's intentional submission of fraudulent information;
- Member becomes an inmate (see **Appendix A** - Definition of Terms) of a Public Institution;
- Member moves out of state;
- Member elects hospice;
- Member becomes Medicare Eligible;
- Member becomes institutionalized in a Long Term Care Facility/Nursing Home; and
- Member elects Home and Community Based Waiver Programs.

The CCN shall immediately notify DHH when it obtains knowledge of any CCN member whose enrollment should be terminated prior to DHH' knowledge. See *CCN-P Policy and Procedure Guide*.

6.10 Notification of Membership to CCN

DHH will notify each CCN at specified times each month of the Medicaid/CHIP eligibles that are enrolled, re-enrolled, or disenrolled from their CCN for the

following month. The CCN will receive this notification through electronic media. See *CCN-P Policy and Procedure Guide* for record layout.

DHH will use its best efforts to ensure that the CCN receives timely and accurate enrollment and disenrollment information. In the event of discrepancies or unresolvable differences between DHH and the CCN, regarding enrollment, disenrollment and/or termination, DHH's decision is final.

6.11 Call Center for CCN Enrollment Questions

DHH through its Enrollment Broker contractor will maintain a toll free telephone number for Medicaid /CHIP potential enrollees and enrollees to call and ask questions or obtain information about the enrollment process and other information, as specified in the *CCN-P Policy and Procedure Guide*, including but not limited to, Coordinated Care Networks available to them.

6.12 Tracking Linkage Availability

The CCN shall identify the maximum number of CCN members it is able to enroll and maintain under this Provider Agreement prior to initial enrollment of Medicaid/CHIP eligibles. The CCN shall accept Medicaid/CHIP enrollees as CCN members in the order in which they are submitted by the Enrollment Broker without restriction {42 CFR §438.6 (d)(1)} as specified by DHH up to the limits specified in *CCN-P Policy and Procedure Guide*, Required Submissions. The CCN agrees to provide services to CCN members up to the maximum enrollment limits indicated for the CCN in *CCN-P Policy and Procedure Guide*. DHH reserves the right to approve or deny the maximum number of CCN members to be enrolled in the CCN based on DHH's determination of the adequacy of CCN capacity.

On a quarterly basis consistent with the *CCN Policy and Procedures Guide*, CCN is to update the maximum enrollment by parish and/or service area. The CCN shall track slot availability and notify DHH's Enrollment Broker when filled slots are near capacity. Upon notification, DHH or the Enrollment Broker will not assign any other potential enrollees to that CCN without consulting the CCN first. The CCN is responsible for maintaining a record of PCP linkages with Medicaid members and provide this information quarterly to DHH.

DHH will notify the CCN when the CCN's enrollment levels are maximized and will not enroll Medicaid/CHIP eligibles when there are no more slots available.

6.13 Billing and Reconciliation

If the CCN desires a reconciliation of the enrollment, re-enrollment, and disenrollment data received from DHH, the CCN shall be responsible for that reconciliation. In the event of discrepancies, the CCN shall notify the Enrollment Broker immediately of the discrepancy, however DHH as the regulatory agency will make the final determination in any disputes that may arise from the reconciliation process.

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7 **MARKETING**

Marketing is defined as any communication from a CCN to a Medicaid/CHIP eligible who is not enrolled in that CCN, that can reasonably be interpreted to influence the recipient to enroll in that particular CCN's Medicaid product, or either to not enroll in, or to disenroll from, another CCN's Medicaid product. All such marketing, informational and instructional materials shall be written in manner and format that may be easily understood, at a reading comprehension level no higher than 6.9 level as specified in 42 CFR § 438.10(b)(1). Activities involving distribution and completion of the CCN enrollment form during the course of enrollment activities is an enrollment function and is considered separate and distinct from marketing and is the sole responsibility of DHH's Enrollment Broker.

Under the Louisiana Coordinated Care Program, all direct marketing to eligibles or potential eligibles will be performed by DHH or its designee in accordance with 1932 (d)(2 A) and 42 CFR §438.104. The CCN shall not market directly to Medicaid potential enrollees (including direct mail advertising, "spam", door-to-door, telephonic, or other "cold call" marketing techniques). The CCN shall not sponsor or attend any marketing activities without notifying DHH. No CCN outreach or marketing shall precede the successful completion of the CCN enrollment process and readiness review or, for initial phase in of CCNs, the launch of the Enrollment Broker information and education campaign. All marketing and educational materials must be approved by DHH prior to use. All marketing/advertising and member education activities and materials must comply with the requirements set forth in the *CCN-P Policy and Procedure Guide*. The CCN shall not release **any** materials related to this Provider Agreement, including but not limited to, enrollment materials, press releases, and articles, without the prior written approval of the Department.

DHH may impose sanctions against the CCN if DHH determines that the CCN distributed directly/indirectly or through any agent, network provider, or independent contractor, marketing materials and/or CCN enrollment forms in violation of this Provider Agreement.

7.1 Marketing Plan and Materials

The CCN shall develop and implement a marketing plan, incorporating DHH's marketing requirements, for participation in Medicaid's Coordinated Care Program. The CCN shall provide a marketing plan detailing the marketing activities it will undertake during the Provider Agreement period. The CCN's marketing plan shall take into consideration the projected enrollment levels. The CCN shall notify DHH of their participation in each community event designed to increase community awareness of their participation in the Coordinated Care Program. Marketing plan requirements are detailed in the *CCN-P Policy and Procedure Guide*.

Enrollment activities by the CCN are **specifically prohibited**. Only written materials describing the CCN, as approved by DHH and distributed by DHH or the DHH Enrollment Broker, can be distributed at such activities. All marketing activities shall comply with *CCN-P Policy and Procedure Guide* and this Provider Agreement.

Materials used for the purpose of marketing to CCN members must be prior approved by DHH and meet the standards for marketing materials outlined in *CCN-P Policy and Procedure Guide*. All written materials must use easily understood language and format in keeping with the *CCN-P Policy and Procedure Guide* and as specified in 42 CFR § 438.10(b)(1).

The CCN must provide DHH with a copy of all publications and displays, including information on when and where they will appear.

7.2 Approval of Marketing Plan and Materials

The CCN shall submit to DHH or its designee a marketing plan and all marketing materials directed at Medicaid eligibles, current CCN members or potential eligibles for approval in accordance with the *CCN-P Policy and Procedure Guide*. These materials include, but are not limited to: materials produced for marketing, member education, and evidence of coverage; member handbook and grievance procedures; all types of media including brochures, leaflets, newspapers, magazines, radio, television, internet-based materials, billboard and yellow page advertisements directed at Medicaid eligibles, current CCN members or potential eligibles.

7.2.1 The CNN shall assure DHH that marketing, including plans and materials are accurate and do not mislead, confuse, or defraud the enrollee/potential enrollee or DHH as specified in Social Security Act § 1932 (d) and 42 CFR § 438.104. Marketing materials must follow the guidance of the *CCN-P Policy and Procedure Guide*, which details prohibited actions as well as written guidance.

7.2.2 Marketing materials cannot contain any assertion or statement (whether written or oral) that:

7.2.2.1 The potential enrollee must enroll in the CCN in order to obtain benefits or in order not to lose benefits.

7.2.2.2 That the CCN is endorsed by CMS, the Federal or State government or similar entity.

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- 7.2.3 The CCN shall distribute all DHH approved materials to its entire service area as indicated in the Provider Agreement;
- 7.2.4 The CCN does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and
- 7.2.5 The CCN shall not, directly or indirectly, engage in door-to-door, telephone or other cold-call marketing activities.

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8 POST ENROLLMENT PROCESS

DHH's Enrollment Broker shall send the CCN a weekly eligibility file. The file shall contain the names, addresses and phone numbers of all newly eligible enrollees assigned to the CCN and an indicator for individuals who are automatic assignments. The CCN shall use the file to identify new members to whom the CCN shall send a welcome packet and conduct a welcome call in accordance with the *CCN-P Policy and Procedure Guide-Member Rights and Responsibilities*.

The post enrollment process for the Coordinated Care Networks shall be as follows:

8.1 Member Identification Card

The CCN shall issue an identification (ID) card within fourteen (14) calendar days of the receipt of information from DHH or the Enrollment Broker.

To ensure immediate access to services, the CCN's providers shall be instructed by the CCN to accept the member's Medicaid ID Card as proof of enrollment in the CCN until the member receives its CCN's ID card. A list of required ID card information is outlined in *CCN-P Policy and Procedure Guide*.

The holder of the member identification card issued by the CCN shall be a CCN member or guardian of a member. If the CCN has knowledge of any CCN member permitting the use of this identification card by any other person, the CCN shall immediately report this violation to DHH or its designee.

The CCN shall also insure that its contractors/network providers can identify members, in a manner which will not result in discrimination against the members, in order to provide or coordinate the provision of all **core** benefits and services and/or expanded services and out of plan services.

8.2 Member Services Availability

The CCN shall maintain an organized, integrated member/patient services function, to be operated during regular business hours within the CCN, to assist members in selection of a primary care provider, provide explanation of the CCN's policies and procedures, (re: access and availability of health services) provide additional information about the primary care providers and/or specialist(s), facilitate referrals to participating specialists, and assist in the resolution of service and/or medical delivery problems and member grievances.

The CCN shall agree to maintain a toll-free telephone number for CCN members' inquiries. The toll-free telephone number shall be required to provide prior authorization/access and information on services during evenings and weekends.

Member Services and the Call Center must be physically located in the United States.

8.3 Member Education

The CCN shall submit to DHH an electronic copy of the procedures to be used to contact CCN members for initial member education for approval prior to Provider Agreement execution. These procedures shall adhere to the enrollment process and procedures outlined in §6 and the post enrollment procedures required in §8 of this Provider Agreement.

The CCN shall have written policies and procedures for educating CCN members about their benefits. The CCN shall educate members regarding the appropriate utilization of services; access to emergency care; and the process for prior authorization of services and situations in which services can be obtained out-of-network. Such education shall be provided no later than ten (10) calendar days from receipt of enrollment data from DHH or its designee, and as needed thereafter. The CCN shall identify and educate members who access the system inappropriately and provide continuing education as needed.

The CCN must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood. Written material must use easily understood language and format and written at the 6.9 level. Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

The CCN must make real-time oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages not just those that Louisiana identifies as prevalent (Spanish and Vietnamese). The enrollee is not to be charged for interpretation services. The CCN must notify its enrollees that oral interpretation is available for any language and written information is available in Spanish and Vietnamese and how to access those services. On materials where this information is provided, the notice should be written in both Spanish and Vietnamese.

Include the following notifications as well:

- a. Notify all enrollees of their right to request and obtain the welcome packet, at least once a year.

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- b. Furnish to each of its enrollees the information specified in this Provider Agreement and *CCN-P Policy and Procedure Guide*, including but not limited to, how to access services, grievance and State Fair Hearing process, and any restrictions on member's freedom of choice among network providers, within the timeframe specified in the *CCN-P Policy and Procedure Guide*, after the CCN receives, from the state or its contracted representative, notice of the recipient's enrollment.
- c. Give each enrollee written notice of any change (that DHH defines as "significant") at least thirty (30) calendar days before the intended effective date of the change.

The CCN shall ensure that where at least five percent (5%) or more of the Medicaid resident population of a parish and/or service area is non-English speaking and speaks a specific foreign language, then materials must be made available, at no charge, in that specific language to assure a reasonable chance for all members to understand how to access the CCN and use services appropriately as specified in 42 CFR §438.10(c) (4) and (5).

The CCN shall have written policies and procedures for educating CCN members about their benefits and how to access them in accordance with the *CCN-P Policy and Procedure Guide*.

The CCN shall coordinate with DHH or its designee member education activities as outlined in *CCN-P Policy and Procedure Guide* to meet the health care educational needs of the CCN members.

The CCN shall ensure all materials and processes do not discriminate against Medicaid CCN members on the basis of their health history, health status or need for health care services. This applies to enrollment, re-enrollment or disenrollment materials and processes from the CCN.

8.3.1 Member Welcome Packets

The CCN shall send welcome packets to new members within ten (10) business days from the effective date of enrollment into the CCN. All contents of the welcome packet shall be reviewed and approved in writing by DHH prior to distribution. The welcome packet shall include, but is not limited to:

- A welcome letter highlighting major program features and contact information for the CCN;
- A Member Handbook;

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- A Member Identification (ID) card, and
- A Provider Directory (also may be available on-line).

The CCN shall adhere to the requirements for the Member Handbook and ID card; and Provider Directory as specified in the *CCN-P Policy and Procedure Guide* and in accordance with 42 CFR §438.10 (f)(6).

8.4 Member Handbook

The CCN must write Member Handbooks in a style and reading level that will accommodate the reading skills of most CCN enrollees. In general, the writing should be at no higher than a 6.9 level, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy. The text must be printed in at least ten-point font, preferably twelve-point font. DHH reserves the right to require evidence that a handbook has been tested against the sixth-grade (6.9) reading-level standard.

8.4.1 At a minimum, the member handbook shall include the following information:

- a. Table of contents;
- b. A general description about how Coordinated Care Networks operate, particularly member rights and responsibilities, appropriate utilization of services including Emergency Room for non-emergent conditions, a description of the PCP selection process, and the PCP's role as coordinator of services;
- c. Member's right to disenroll from CCN;
- d. Member's right to change providers within the CCN;
- e. Any restrictions on the member's freedom of choice among CCN providers;
- f. Member's rights and protections, as specified in 42 CFR §438.100 and *SECTION 8.4 - MEMBER RIGHTS AND RESPONSIBILITIES* of the Provider Agreement;
- g. The amount, duration, and scope of benefits available under the Provider Agreement with DHH in sufficient detail to ensure that members understand the benefits to which they are entitled and

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- information about health education and promotion programs, including chronic care management;
- h. Procedures for obtaining benefits, including prior authorization requirements;
 - i. The extent to which, and how, members may obtain benefits, including family planning services and specialized behavioral health services from out-of-network providers;
 - j. The extent to which, and how, after-hours and emergency coverage are provided, including:
 - 1. What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR §438.114(a);
 - 2. Prior authorization is not required for emergency services;
 - 3. The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent;
 - 4. The mechanism, incorporated in the grievance procedures, in which a member may submit, whether oral or in writing, a service authorization request for the provision of services;
 - 5. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the Provider Agreement; and
 - 6. That, subject to the provisions of 42 CFR §438, the member has a right to use any hospital or other setting for emergency care.
 - k. The post-stabilization care services rules set forth in 42 CFR 422.113(c);
 - l. Policy on referrals for specialty care, including behavioral health services and for other benefits not furnished by the member's primary care provider;

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- m. How and where to access any benefits that are available under the Louisiana Medicaid State Plan but, are covered under the Provider Agreement with DHH, including pharmacy cost sharing for adults;
- n. How transportation is provided;
- o. That the member has the right to refuse to undergo any medical service, diagnoses, or treatment or to accept any health service provided by the CCN if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds;
- p. For counseling or referral services that the CCN does not cover because of moral or religious objections, the CCN is required to furnish information on how or where to obtain the service.
- q. Grievance, appeal and state fair hearing procedures and time frames, as described in 42 CFR §§438.400 through 438.424 and SECTION 9 -GRIEVANCE, APPEALS AND STATE FAIR HEARINGS of the Provider Agreement;

- 1. Grievance, appeal and fair hearing procedures and that includes the following:
 - For State fair hearing:
 - The right to hearing;
 - The method for obtaining a hearing; and
 - The rules that govern representation at the hearing.
 - The right to file grievances and appeals.
 - The requirements and timeframes for filing a grievance or appeal.
 - The availability of assistance in the filing process.
 - The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.
 - The fact that, when requested by the enrollee:

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- Benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and
 - The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.
 - The Division of Administration – Administrative Law Judge Division shall make the final determination as to whether services must be provided.
- r. Advance Directives, set forth in 42 FR §438.6(i)(2) - A description of advance directives which shall include:
1. The CCN policies related to advance directives;
 2. Member’s rights under the Louisiana state law, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; and changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective change;
 3. Information that members can file complaints about the failure to comply with an advance directive with DHH via DHH’s Customer Service Unit and the hotline’s telephone number; and
 4. Information about where a member can seek assistance in executing an advance directive and to whom copies should be given;
- s. Information to call the Medicaid Customer Service Unit toll free number or visit a local Medicaid eligibility office to report if family size changes;

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- t. How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a “no show”;
- u. A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;
- v. How to obtain emergency and non-emergency medical transportation;
- w. Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;
- x. Information about the requirement that a member shall notify the CCN immediately if he or she has a Workman’s Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in a auto accident;
- y. Reporting requirements for the member that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported to DHH’s Medicaid Customer Service Unit;
- z. Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the CCN or DHH. This shall include a statement that the member is responsible for protecting their ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member’s Medicaid eligibility and/or legal action;
- aa. Instructions on how to request multi-lingual interpretation and translation when needed at no cost to the member. This information shall be included in all versions of the handbook in English, Spanish and Vietnamese;
- bb. Information on the member’s right to a second opinion at no cost and how to obtain it;
- cc. Any additional text provided to the CCN by DHH;
- dd. The date of the last revision;

- ee. Additional information that is available upon request, including the following:
 - o Information on the structure and operation of the CCN; and
 - o Physician incentive plans [42 CFR 438.6(h)].
 - o Service utilization policies; and
- ff. How to report alleged marketing violations to DHH utilizing Marketing Complaint Form. (See Appendix HH in CCN-P Policy and Procedure Guide)

8.5 Member's Rights and Responsibilities

The CCN shall furnish CCN members with both verbal and written information about the nature and extent of their rights and responsibilities as a member of the CCN.

8.5.1 Member Rights

The rights afforded to current members are detailed in *CCN-P Policy and Procedure Guide*, Members' Bill of Rights. The written information shall be written at a reading comprehension level no higher than 6.9 grade level, or as determined appropriate by DHH. The minimum written information shall include:

- a. The right to receive information as described in 42 CFR §438.10 and throughout the Provider Agreement;
- b. The right to be treated with respect and with due consideration for his or her dignity and privacy;
- c. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;
- d. The right to receive restorative or rehabilitative services in a community or home setting, or in a nursing home setting;

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- e. The right to participate in decisions regarding his or her health care, including the right to refuse treatment; and the right to the following:
 - i. Complete information about their specific condition and treatment options, regardless of cost or benefit coverage, and to seek second opinions;
 - ii. Information about available experimental treatments and clinical trials and how such research can be accessed; and
 - iii. Assistance with care coordination from the PCP's office.
- f. The right to be free from any form of restraint or seclusion as a means of coercion, discipline, retaliation or convenience;
- g. The right to express a concern or appeal about their CCN or the care it provides and receive a response in a reasonable period of time;
- h. The right to receive a copy of their medical records, including, if the HIPAA privacy rule applies, the right to request that the records be amended or corrected as allowed in 45 CFR Part 164;
- i. The right to implement an advance directive as required in 42 CFR §438.10(g)(2); written information is updated as required in 42 CFR §438.6(i)(3) and (4) which specifies that the written information must reflect changes in state law as soon as possible, but no later than ninety (90) days after the effective date of change; and right to file a grievance concerning noncompliance with the advance directive requirements to DHH or other appropriate certification or licensing agency as allowed in 42 CFR §438 Subpart I;
- j. Right to choose his or her health professional to the extent possible and appropriate, in accordance with 42 CFR §438.6(m);
- k. Be furnished health care services in accordance with 42 CFR §438.206 through 438.210; and
- l. Freedom to exercise the rights described herein without any adverse effect on the member's treatment by DHH, the CCN or the CCN's contractors or providers.

8.5.2 Member Responsibility

The CCN members' responsibilities shall include but are not limited to:

- a. Informing the CCN of the loss or theft of their ID card;
- b. Presenting their CCN ID card when using health care services;
- c. Being familiar with the CCN procedures to the best of the member's abilities;
- d. Calling or contacting the CCN to obtain information and have questions clarified;
- e. Providing participating network providers with accurate and complete medical information;
- f. Following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible; and
- g. Making every effort to keep any agreed upon appointments, and follow-up appointments; and accessing preventive care services.

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9 GRIEVANCE AND APPEAL PROCEDURES

The CCN must have a grievance system that complies with 42 CFR §438 Subpart F. The CCN shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances and appeals in accordance all applicable state and federal laws.

The CCN's grievance and appeals procedures and any changes thereto must be approved in writing by DHH prior to their implementation and must include at a minimum the requirements set forth in this document and *CCN-P Policy and Procedure Guide*. The CCN shall refer all CCN members who are dissatisfied with the CCN or its contractor in any respect to the CCN's designee authorized to review and respond to grievances and appeals and require corrective action. The member must exhaust the CCN's internal grievance/appeal procedures prior to accessing the State Fair Hearing process.

The CCN shall not create barriers to timely due process. The CCN shall be subject to sanctions if it is determined by the Department the CCN has created barriers to timely due process, and/or, if ten (10) percent or higher of grievance decisions appealed to a State Fair Hearing level within a twelve (12) month period have been reversed or otherwise resolved in favor of the member. Examples of creating barriers shall include but not be limited to:

- Including binding arbitration clauses in CCN member choice forms
- Labeling complaints as inquiries and funneled into an informal review
- Failing to inform members of their due process rights
- Failing to log and process grievances and appeals
- Failure to issue a proper notice including vague or illegible notices
- Failure to inform of continuation of benefits
- Failure to inform of right to State Fair Hearing

9.1 Definitions

9.1.1 **Action** means:

9.1.1.1 The denial or limited authorization of a requested service, including the type or level of service;

9.1.1.2 The reduction, suspension, or termination of a previously authorized service;

9.1.1.3 The denial, in whole or in part, of payment for a service;

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- 9.1.1.4 The failure to provide services in a timely manner, as defined by § 4.17 and § 4.19 of this Provider Agreement;
- 9.1.1.5 The failure of the CCN to act within the timeframes provided in § 9.7.1 of this Provider Agreement; or
- 9.1.1.6 For a resident of a rural area with only one CCN, the denial of a Medicaid member's request to exercise his or her right, under 42 C.F.R. § 438.52(b)(2)(ii), to obtain services outside the CCN's network.

9.1.2 Appeal

A request for review of an action, as "action" is defined in this section.

9.1.3 Grievance

An expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. The term is also used to refer to the overall system that includes grievances and appeals handled at the CCN level.

9.2 General Requirements

9.2.1 Grievance System

The CCN must have a system in place for members that include a grievance process, an appeal process, and access to the State Fair Hearing system, once the CCN's appeal process has been exhausted.

9.2.2 Filing Requirements

9.2.2.1 Authority to File

- 9.2.2.1.1 A member may file a grievance and a CCN level appeal, and may request a State Fair Hearing, once the CCN's appeals process has been exhausted.
- 9.2.2.1.2 A network provider, acting on behalf of the member and with the member's written consent, may file an

appeal. A network provider may file a grievance or request a State Fair Hearing on behalf of a member,

9.2.2.2 Timing

The member must be allowed thirty (30) calendar days from the date on the CCN's notice of action. Within that timeframe the member or a representative acting on their behalf may file an appeal or the provider may file an appeal on behalf of the member.

9.2.3 Procedures

9.2.3.1 The member may file a grievance either orally or in writing with the CCN.

9.2.3.2 The member, or a representative acting on their behalf, or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed appeal request.

9.3 Notice of Grievance and Appeal Procedures

The CCN shall ensure that all CCN members are informed of State Fair Hearing process and of the CCN's grievance and appeal procedures. The CCN shall provide to each member a member handbook that shall include descriptions of the CCN's grievance and appeal procedures. Forms on which members may file grievances, appeals, concerns or recommendations to the CCN shall be available through the CCN, and must be provided upon request of the member. The CCN shall make all forms easily available on the CCN's website.

9.4 Grievance/Appeal Records and Reports

The CCN must maintain records of grievances and appeals. A copy of grievances log and records of disposition of appeals shall be retained for six (6) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular six (6) year period, whichever is later.

The CCN shall electronically provide DHH with a monthly report of the grievances/appeals in accordance with the requirements outlined in the *CCN-P*

Policy and Procedure Guide, to include, but not be limited to: member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; resolutions and resulting corrective action. Reports with personally identifying information redacted will be made available for public inspection. The CCN will be responsible for promptly forwarding any adverse decisions to DHH for further review/action upon request by DHH or the CCN member. DHH may submit recommendations to the CCN regarding the merits or suggested resolution of any grievance/appeal. See *CCN-P Policy and Procedure Guide*.

9.5 Handling of Grievances and Appeals

The grievance and appeal procedures shall be governed by the following requirements:

9.5.1 General Requirements

In handling grievances and appeals, the CCN must meet the following requirements:

9.5.1.1 Give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

9.5.1.2 Acknowledge receipt of each grievance and appeal.

9.5.1.3 Ensure that the individuals who make decisions on grievances and appeals are individuals:

9.5.1.3.1 Who were not involved in any previous level of review or decision-making; and

9.5.1.3.2 Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by DHH, in treating the member's condition or disease:

9.5.1.3.2.1 An appeal of a denial that is based on lack of medical necessity.

9.5.1.3.2.2 A grievance regarding denial of expedited resolution of an appeal.

9.5.1.3.2.3 A grievance or appeal that involves clinical issues.

9.5.2 Special Requirements for Appeals

The process for appeals must:

9.5.2.1 Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution. The enrollee or provider may file an expedited appeal either orally or in writing. No additional enrollee follow-up is required.

9.5.2.2 Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The CCN must inform the member of the limited time available for this in the case of expedited resolution.)

9.5.2.3 Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process.

9.5.2.4 Include, as parties to the appeal:

9.5.2.4.1 The member and his or her representative; or

9.5.2.4.2 The legal representative of a deceased member's estate.

9.5.3 Training of CCN Staff

The CCN's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers.

9.5.4 Identification of Appropriate Party

The appropriate individual or body within the CCN having decision making authority as part of the grievance/appeal procedure shall be identified.

9.5.5 Failure to Make a Timely Decision

Appeals shall be resolved no later than stated time frames and all parties shall be informed of the CCN's decision. If a determination is not made by the above time frames, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

9.5.6 Right to State Fair Hearing

The CCN shall inform the member of their right to seek a State Fair Hearing if the member is not satisfied with the CCN's decision in response to an appeal.

9.6 Notice of Action

9.6.1 Language and Format Requirements

The notice must be in writing and must meet the language and format requirements of 42 C.F.R. §438.10(c) and (d) to ensure ease of understanding.

9.6.2 Content of Notice

The notice must explain the following:

9.6.2.1 The action the CCN or its contractor has taken or intends to take.

9.6.2.2 The reasons for the action.

9.6.2.3 The member's or the provider's right to file an appeal with the CCN.

9.6.2.4 The member's right to request a State Fair Hearing, after the CCN's appeal process has been exhausted.

9.6.2.5 The procedures for exercising the rights specified in this section.

9.6.2.6 The circumstances under which expedited resolution is available and how to request it.

9.6.2.7 The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the

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circumstances under which the member may be required to repay the costs of these services.

9.6.3 Timing of Notice

The CCN must mail the notice within the following timeframes:

9.6.3.1 For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action, except as permitted under 42 C.F.R. §§ 431.213 and 431.214.

9.6.3.2 For denial of payment, at the time of any action affecting the claim.

9.6.3.3 For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if:

9.6.3.3.1 The member, or the provider, requests extension; or

9.6.3.3.2 The CCN justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.

9.6.3.4 If the CCN extends the timeframe in accordance with § 9.6.3.3.1 or 9.6.3.3.2 above, it must:

9.6.3.4.1 Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and

9.6.3.4.2 Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

9.6.3.5 On the date the timeframe for service authorization as specified in § 9.6.3.3 expires.

9.6.3.6 For expedited service authorization decisions where a provider indicates, or the CCN determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CCN must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three (3) working days after receipt of the request for service.

The CCN may extend the three (3) business day time period by up to fourteen (14) calendar days if the member requests an extension, or if the CCN justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.

9.6.3.7 DHH may conduct random reviews to ensure that members are receiving such notices in a timely manner.

9.7 Resolution and Notification

Basic Rule: The CCN must dispose of a grievance and resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within the timeframes established in § 9.7.1 below.

9.7.1 Specific Timeframes:

9.7.1.1 Standard Disposition of Grievances

For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety (90) days from the day the CCN receives the grievance.

9.7.1.2 Standard Resolution of Appeals

For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the CCN receives the appeal. This timeframe may be extended under § 9.7.2 of this section.

9.7.1.3 Expedited Resolution of Appeals

For expedited resolution of an appeal and notice to affected parties, the timeframe is established as three (3) working days after the CCN receives the appeal. This timeframe may be extended under § 9.7.2 of this section.

9.7.2 Extension of Timeframes

9.7.2.1 The CCN may extend the timeframes from § 9.7.1 of this section by up to fourteen (14) calendar days if:

9.7.2.1.1 The member requests the extension; or

9.7.2.1.2 The CCN shows (to the satisfaction of DHH, upon its request) that there is need for additional information and how the delay is in the member's interest.

9.7.2.2 Requirements Following Extension

If the CCN extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.

9.7.3 Format of Notice

9.7.3.1 Grievances

DHH will specify the method the CCN will use to notify a member of the disposition of a grievance. See *CCN Policy and Procedures Guide*.

9.7.3.2 Appeals

9.7.3.2.1 For all appeals, the CCN must provide written notice of disposition.

9.7.3.2.2 For notice of an expedited resolution, the CCN must also make reasonable efforts to provide oral notice.

9.7.4 Content of Notice of Appeal Resolution

The written notice of the resolution must include the following:

9.7.4.1 The results of the resolution process and the date it was completed.

9.7.4.2 For appeals not resolved wholly in favor of the members:

9.7.4.2.1 The right to request a State Fair Hearing, and how to do so;

9.7.4.2.2 The right to request to receive benefits while the hearing is pending, and how to make the request; and

9.7.4.2.3 That the member may be held liable for the cost of those benefits if the hearing decision upholds the CCN's action.

9.7.5 Requirements for State Fair Hearings

DHH shall comply with the requirements of 42 CFR §§431.200(b), 431.220(5) and 42 CFR §§438.414 and 438.10(g)(1). The CCN shall comply with all requirements as outlined in this Provider Agreement and the *CCN-P Policy and Procedure Guide*.

9.7.5.1 Availability

If the member has exhausted the CCN level appeal procedures, the member may request a State Fair Hearing within thirty (30) days from the date of the CCN's notice of resolution.

9.7.5.2 Parties

The parties to the State Fair Hearing include the CCN as well as the member and his or her representative or the representative of a deceased member's estate.

9.8 Expedited Resolution of Appeals

General rule: The CCN must establish and maintain an expedited review process for appeals, when the CCN determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could

seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

9.8.1 Punitive Action

The CCN must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a member's appeal.

9.8.2 Action Following Denial of a Request for Expedited Resolution

If the CCN denies a request for expedited resolution of an appeal, it must:

9.8.2.1 Transfer the appeal to the timeframe for standard resolution in accordance with § 9.7.1.2;

9.8.2.2 Make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

9.8.2.3 This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an Action or require a Notice of Action. The Member may file a grievance in response to this decision.

9.8.3 Failure to Make a Timely Decision

Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the CCN's decision. If a determination is not made by the above timeframes, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

9.8.4 Process

The CCN is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution. The member or provider may file an expedited appeal either orally or in writing. No additional follow-up may be required.

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The CCN shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

9.8.5 Authority to File

The Medicaid member or their provider may file an expedited appeal either orally or in writing. No additional member follow-up is required.

9.8.6 Format of Resolution Notice

In addition to written notice, the CCN must also make reasonable effort to provide oral notice.

9.9 Continuation of Benefits While the CCN Appeals And State Fair Hearing Is Pending

9.9.1 Terminology

As used in this section, "timely" filing means filing on or before the later of the following:

9.9.1.1 Within ten (10) days of the CCN mailing the notice of action.

9.9.1.2 The intended effective date of the CCN's proposed action.

9.9.2 Continuation of Benefits

The CCN must continue the member's benefits if:

9.9.2.1 The member or the provider files the appeal timely;

9.9.2.2 The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

9.9.2.3 The services were ordered by an authorized provider;

9.9.2.4 The original period covered by the original authorization has not expired; and

9.9.2.5 The member requests extension of benefits.

9.9.3 Duration of Continued or Reinstated Benefits

If, at the member's request, the CCN continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

9.9.3.1 The member withdraws the appeal.

9.9.3.2 Ten (10) days pass after the CCN mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached.

9.9.3.3 A State Fair Hearing Officer issues a hearing decision adverse to the member.

9.9.3.4 The time period or service limits of a previously authorized service has been met.

9.9.4 Member Responsibility for Services Furnished While the Appeal is pending

If the final resolution of the appeal is adverse to the member, that is, upholds the CCN's action, the CCN may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 42 C.F.R. § 431.230(b).

9.10 Information About the Grievance System to Providers and Contractors

The CCN must provide the information specified at 42 C.F.R. § 438.10(g)(1) about the grievance system to all providers and contractors at the time they enter into a contract.

9.11 Recordkeeping and Reporting Requirements

Reports of grievances and resolutions shall be submitted to DHH as specified in **§9.4 and 10.2** of this Provider Agreement. The CCN shall not modify the grievance procedure without the prior written approval of DHH.

9.12 Effectuation of Reversed Appeal Resolutions

9.12.1 Services not Furnished While the Appeal is Pending

If the CCN or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CCN must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires.

9.12.2 Services Furnished While the Appeal is Pending

If the CCN or the State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the CCN must pay for those services, in accordance with this Provider Agreement.

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10 REPORTING REQUIREMENTS

The CCN is responsible for complying with all the reporting requirements established by DHH. As per 42 CFR §438.242(a),(b)(1)(2)and(3), the CCN shall maintain a health information system that collects, analyzes, integrates and reports data that complies with DHH and federal reporting requirements. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and member disenrollment for reasons other than loss of Medicaid eligibility. The CCN shall collect data on member and provider characteristics and on services furnished to members as specified in *CCN-P Policy and Procedure Guide and CCN-P Systems Companion Guide*.

The CCN must demonstrate the capability to connect to DHH's FI using TCP/IP protocol based on a specific port at no cost to DHH or its FI. Connectivity must be verified by DHH's FI in writing to DHH. The CCN shall provide DHH with a sample of all hard copy reports as specified in the CCN Enrollment Process (*See CCN-P Policy and Procedure Guide*). The requirements for electronic files submission are specified in the *CCN-P Policy and Procedure Guide and CCN-P Systems Companion Guide*.

The CCN shall provide to DHH and any of its designee's copies of agreed upon reports generated by the CCN concerning CCN members and any additional reports as requested in regard to performance under this Provider Agreement.

DHH will provide the CCN with the appropriate reporting formats, instructions, submission timetables, and technical assistance when required.

Reporting periods, data elements and format requirements are specified in the *CCN-P Policy and Procedure Guide and/or CCN-P Systems Companion Guide*.

All reports shall be submitted in accordance with the schedule outlined in the § 13.3 of this Provider Agreement. In the event that there are no instances to report, the CCN shall submit null reports.

The Minimum Data Elements and required formats for these reports are outlined in the *CCN-P Systems Companion Guide*. Additional reports may be required in the *CCN-P Policy and Procedure Guide*.

As required by 42 CFR §438.604(a), (b), and 42 CFR §438.606, the CCN shall certify all submitted data, documents and reports. The data that must be certified include, but are not limited to, enrollment information, financial reports, encounter data, and other information as specified within in this Provider Agreement. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The CCN must submit the certification concurrently with the certified data and documents.

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The data shall be certified by one of the following:

- (1) CCN's Chief Executive Officer (CEO);
- (2) CCN's Chief Financial Officer (CFO); or
- (3) An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.

Certification shall be submitted concurrently with the certified data.

10.1 CCN's Network of Providers and Contractors

The CCN shall furnish to DHH and/or its designee a monthly report of all network providers and contractors enrolled in the CCN's network, including but not limited to, primary care providers, hospitals, home health agencies, medical vendors, specialty or referral providers and any other providers which may be enrolled for purposes of providing health care services to CCN members under this Provider Agreement.

The CCN shall also furnish to DHH or its designee adequate copies of the PCP listing as requested by DHH. DHH will provide the CCN with Medicaid provider identification numbers. The CCN is responsible for maintaining a record of PCP linkages with Medicaid/CHIP members and provide this information quarterly to DHH.

It shall be the CCN's responsibility to assure confidentiality of the Medicaid Providers' identification number and indemnity of DHH in accordance with § 14.22 of this Provider Agreement.

DHH is to be provided advance copies of all updates that include material changes, not less than ten (10) working days in advance of distribution. Any provider no longer taking new patients must be clearly identified. Any age restrictions for a provider must be clearly identified. The Minimum Data Elements and required format for this listing may be found in the *CCN-P Policy and Procedure Guide and Systems Companion Guide*.

For any provider not enrolled in the Medicaid program, the CCN shall furnish to DHH, a monthly file utilizing the Minimum Data Elements and required format identified in the *CCN-P Policy and Procedure Guide*.

The CCN shall provide annual individual PCP and practice quality performance measure profiling as specified the *CCN-P Policy and Procedure Guide*.

10.2 FQHC/RHC Encounter Reporting

The CCN shall submit on a quarterly basis by date of service, a report of encounter data of all contracting FQHCs and RHCs for State Plan required reconciliation purposes. Refer to the *CCN-P Systems Companion Guide* for FQHC/RHC Encounter Reporting for reporting specifications. The encounter data shall be submitted no later than sixty (60) days following the quarter's end.

10.3 Reporting of Other Insurance

The CCN shall notify DHH within five (5) business days of identification of any member identified as being enrolled in Medicare. The data elements and format requirements are specified in the *CCN-P Systems Companion Guide - Section 20 - TPL Reporting*. The CCN shall submit a quarterly report summarizing all members identified in the format specified in this *Guide* to DHH by the fifteenth (15th) of the following month.

10.4 Individual Encounter Reporting

The CCN must submit encounter data to DHH for every service rendered to a member for which the CCN paid within ninety (90) days of the service (See *CCN-P Systems Companion Guide*. CCNs shall submit monthly reports to DHH on denied services. Denied codes will be limited to specific reasons codes as determined by DHH and as specified in the *CCN-P Policy and Procedures Guide and CCN-P Systems Companion Guide*. The CCN shall ensure data received from providers is accurate and complete by:

10.4.1 Verifying the accuracy and timeliness of reported data;

10.4.2 Screening the data for completeness, logic, and consistency; and

10.4.3 Collecting service information in standardized format to the extent feasible and appropriate.

Individual encounter data shall be reported as specified in the schedule outlined in §13.2 utilizing the file requirements as specified in the *CCN-P Systems Companion Guide*. In the event a national standard for submitting encounter data is developed, the CCN agrees to implement the standards' as directed by DHH. CCN shall submit encounter data utilizing the HIPAA compliant transaction format. The data elements and required format are identified in the *CCN-P Systems Companion Guide*.

For encounter data submissions, the CCN shall submit 95% of their encounter data at least monthly due no later than the twenty-fifth (25th) calendar day of the month following the month in which they were processed and approved/paid,

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including encounters reflecting a zero dollar amount (\$0.00). The CCN CEO or CFO shall attest to the truthfulness, accuracy, and completeness of all encounter data submitted.

Encounter data shall be submitted in the required format established by DHH in the *CCN-P Systems Companion Guide*. Nothing in this Provider Agreement shall prohibit the CCN from submitting encounter data more frequently than monthly or as specified in the schedule outlined in §13.2 utilizing the file requirements specified in the *CCN-P Systems Companion Guide*. Each encounter data submission shall be accompanied by a statement of certification of the number of encounters identified by date of service.

DHH shall conduct validation studies of encounter data, testing for timeliness, accuracy and completeness. All submitted data must be 95% correct no later than ninety (90) days following the end of the month of submission, or on a schedule agreed upon by DHH. There is no limit on the number of times encounter data can be resubmitted within the ninety (90) day limit. Submissions shall be comprised of encounter records, or adjustments to previously submitted records, which the CCN has received and processed from provider encounter or claims records of any contracted services rendered to the member.

Encounter data received from the CCN will be enhanced and edited by standards established by DHH. The enhanced encounter record will contain additional data elements applied by the Medicaid Management Information System (MMIS) and will contain specific encounter/ edit information. For example, enhancements may include descriptions of edits, descriptions of procedure codes and diagnoses, the disposition of the encounter; e.g. PAY, EOB or DENY and other relevant information. The CCN will receive an edit report (*CCN-P Systems Companion Guide*) for each encounter submission. The CCN shall provide a monthly summary which identifies the number of encounters submitted and identified by the date of service. This summary is due to DHH five (5) business days after the end of the month in a format specified in the *CCN-P Systems Companion Guide*.

10.5 Abortion Reporting

The CCN shall submit on a monthly basis, a report of all therapeutic abortions performed. The report shall include medical records to support each abortion performed, a copy of the completed abortion statement and a copy of the police report if applicable. See the *CCN-P Policy and Procedure Guide* for the Abortion guidelines.

10.6 Grievances/Appeal Log Summary Reporting

The CCN shall log grievance/appeal information regarding all active and resolved grievances/appeals on a monthly basis and submit the log to DHH monthly. The Minimum Data Elements and required formats are identified in *the CCN-P Policy and Procedure Guide*.

10.7 Disenrollment Reporting

The CCN shall submit to DHH disenrollment requests for approval in accordance with §§ 6.7 & 6.8 of this Provider Agreement. The CCN shall immediately notify DHH when it obtains knowledge of any CCN member whose enrollment should be terminated. See *CCN-P Policy and Procedure Guide* for procedures for disenrollment.

10.8 EPSDT Reporting

The CCN shall accurately report to DHH all EPSDT and well-child services, referrals for corrective treatment as a result of well-child screenings, blood lead screenings, and access to preventive services as required for the mandated CMS 416 report as specified in the *CCN-P Policy and Procedure Guide*.

10.9 Quality Assessment and Performance Improvement

The CCN will submit reports of Quality Assessment and Performance Improvement (QAPI) activities in accordance with the reporting section and periodicity contained in § 4.15.6 and the *CCN-P Policy and Procedure Guide* of this Provider Agreement.

The CCN shall report all performance measures as indicated by DHH in the *CCN Quality Companion Guide*.

The CCN shall submit a description of the PIP with results in a format approved by DHH in accordance with *CCN-P Policy and Procedure Guide*.

The CCN shall report to DHH an evaluation of the impact and effectiveness of its QAPI program annually. This shall include, but is not limited to, all care management services.

10.10 Member Satisfaction Survey

The CCN will conduct an annual Member Satisfaction Survey, utilizing the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and methodology. The CCN will submit the survey results and a description of the survey process, including the survey tool and methodology used to DHH in accordance with *CCN-P Policy and Procedure Guide*. DHH will coordinate with

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the CCN to determine the schedule for conducting the survey and submitting the results to DHH. The CCN shall utilize NCQA CAHPS vendor to conduct member surveys.

The CCN shall provide the survey results to members upon request.

10.11 Provider Satisfaction Survey

The CCN will conduct an annual Provider Satisfaction Survey utilizing a survey tool and methodology approved by DHH. DHH will coordinate with the CCN to determine the schedule for conducting the survey and submitting the results to DHH in accordance with *CCN-P Policy and Procedure Guide*.

10.12 Additional Reports

The CCN shall prepare and submit any other reports as required and requested by DHH, any of DHH designees, and/or CMS, that is related to the CCN's duties and obligations under this Provider Agreement. Information considered to be of a proprietary nature shall be clearly identified as such by the CCN at the time of submission. DHH will make every effort to provide a sixty (60) day notice of the submission to give the CCN adequate time to prepare the reports.

10.13 Ownership Disclosure

Federal laws require full disclosure of ownership, management, and control of Medicaid prepaid health plans (42 CFR §455.100-455.104). Form CMS 1513, Ownership and Control Interest Statement, is to be submitted to DHH with this Provider Agreement; then resubmitted prior to implementation for each Provider Agreement period or when any change in the CCN's management, ownership or control occurs. The CCN agrees to report any changes in ownership and disclosure information to DHH within thirty (30) calendar days prior to the effective date of the change.

10.14 Information Related to Business Transactions

The CCN agrees to furnish to DHH or to the U.S. Department of Health & Human Services (HHS) information related to significant business transactions as set forth in 42 CFR §455.105. Failure to comply with this requirement may result in termination of this Provider Agreement.

The CCN also agrees to submit, within thirty-five (35) days of a request made by DHH, full and complete information about:

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- a. The ownership of any contractor with whom the CCN has had business transactions totaling more than \$25,000 during the twelve (12) month period ending on the date of this request; and
- b. Any significant business transactions between the CCN and any wholly owned supplier, or between the CCN and any contractor, during the five (5) year period ending on the date of this request.

For the purpose of this Provider Agreement, “significant business transactions” means any business transaction or series of transactions during any state fiscal year that exceed the \$25,000 or five (5) percent of the CCN’s total operating expenses whichever is greater.

10.15 Information on Persons Convicted of Crimes

The CCN agrees to furnish DHH and HHS information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR §455.106. Failure to comply with this requirement may lead to termination of this Provider Agreement.

10.16 Errors

The CCN agrees to prepare complete and accurate reports for submission to DHH as defined in § 13.3 and in the format described in the *CCN-P Policy and Procedure Guide and CCN-P Systems Companion Guide*. If after preparation and submission, a CCN error is discovered either by the CCN or DHH; the CCN shall correct the error(s) and submit accurate reports as follows:

- a. For encounters - in accordance with the timeframes specified in §13.3 of this Provider Agreement.
- b. For all reports - Fifteen (15) calendar days from the date of discovery by the CCN or date of written notification by DHH (whichever is earlier). DHH may at its discretion extend the due date if an acceptable corrective action plan has been submitted and the CCN can demonstrate to DHH’s satisfaction the problem cannot be corrected within fifteen (15) calendar days.

Failure of the CCN to respond within the above specified timeframes may result in a loss of any money due the CCN and the assessment of monetary penalties as provided in § 13.3 of this Provider Agreement.

10.17 Coding Requirements

The CCN and its contractors must use the coding sources defined in the *CCN-P Systems Companion Guide* when reporting data to DHH.

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11 MONITORING

11.1 Inspection, Evaluation and Audit of Records

At any time HHS, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, DHH, and/or any of the designees of the above, and as often as they may deem necessary during the Provider Agreement period and for a period of six (6) years from the expiration date of this Provider Agreement (including any extensions to the Provider Agreement), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of this Provider Agreement and *CCN-P Policy and Procedure Guide* and any other applicable rules.

The CCN and contracted providers shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have the right to examine and make copies, excerpts or transcripts from all records, contact and conduct private interviews with CCN clients, employees, and contractors and do on-site reviews of all matters relating to service delivery as specified by this Provider Agreement. *See CCN-P Policy and Procedure Guide.*

As per 42 CFR §§438.6(g) and 434.6(a)(5), the State and HHS may inspect and audit any financial records of the entity or its subcontractors. There shall be no restrictions on the right of the state or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs.

The CCN and all of its contractors will make office work space available for any of the above-mentioned entities or their designees when the entities are inspecting or reviewing any records related to the provisions of services under this Provider Agreement. If any litigation, claim, or other action involving the records has 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. This provision is applicable to any contractor and must be included in all contracts. DHH and/or any designee will also have the right to:

11.1.1 Inspect and evaluate the qualifications and certification or licensure of CCN's contractors;

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- 11.1.2 Evaluate, through inspection of CCN and its contractor's facilities or otherwise, the appropriateness and adequacy of equipment and facilities for the provision of quality health care to members;
- 11.1.3 Evaluate the CCN's performance for the purpose of determining compliance with the requirements of the Provider Agreement;
- 11.1.4 Audit and inspect any of CCN's or its contractor's records that pertain to health care or other services performed under this Provider Agreement; determine amounts payable under this Provider Agreement; or the capacity of the CCN to bear the risk of financial losses;
- 11.1.5 Audit and verify the sources of data and any other information furnished by the CCN in response to reporting requirements of this Provider Agreement, including data and information furnished by contractors;
- 11.1.6 The CCN agrees to provide, upon request, all necessary assistance in the conduct of the evaluations, inspections, and audits.
- 11.1.7 DHH shall monitor enrollment and termination practices and ensure proper implementation of the CCN's grievance procedures, in compliance with 42 CFR §438.226-438.228. DHH and its designee shall have access to all information related to complaints and grievances and appeals filed by CCN members.

The CCN agrees that all statements, reports and claims, financial and otherwise, shall be certified as true, accurate, and complete, and the CCN shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, this Provider Agreement, and DHH policy.

11.2 Medical Records Requirements

The CCN will require network providers/contractors to maintain up-to-date medical records at the site where medical services are provided for each CCN member enrolled under this Provider Agreement. Each member's record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment. The CCN shall ensure within its own provider network that DHH or its designee shall have immediate and complete access to all records pertaining to the health care services provided to CCN members. Medical record requirements are further defined in the *CCN-P Policy and Procedure Guide*. The CCN shall ensure the confidentiality of medical records in accordance with 42 CFR § 438.224 and 45 CFR Parts 160 and 165 subparts A and E. The CCN's Notice of

Privacy Practices shall put members on notice that their information will be subject to treatment, payment and operations disclosures within the CCN.

11.3 Record Retention

All records originated or prepared in connection with CCN's performance of its obligations under this Provider Agreement, 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 CCN and its contractors in accordance with the terms and conditions of this Provider Agreement.

The CCN further 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 this Provider Agreement, and as further required by DHH, for a period of six (6) years from the expiration date of the Provider Agreement, including any Provider Agreement 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 CCN stores records on microfilm or microfiche, CCN hereby agrees to produce at CCN's expense, legible hard copy records upon the request of state or federal authorities, within fifteen (15) calendar days of the request.

11.4 Verification of Services Provided

In accordance with 42 CFR §455.1(a)(2) the CCN shall develop a mechanism in which it can verify all services claimed to be provided, have been provided. The CCN shall report on an annual basis the findings of such an investigation(s) and corrective action taken.

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12 DHH RESPONSIBILITIES

12.1 DHH Provider Agreement Management

The DHH will be responsible for the administrative oversight of the Coordinated Care Networks. As appropriate, DHH will provide clarification of Coordinated Care Network requirements and Medicaid policy, regulations and procedures. The DHH will be responsible for oversight of this Provider Agreement. All Medicaid policy decision making or Provider Agreement interpretation will be made solely by DHH. The oversight of this Provider Agreement will be conducted in the best interests of DHH and the CCN members.

Whenever DHH is required by the terms of this Provider Agreement to provide written notice to the CCN, such notice will be signed by the Medicaid Director or his designee.

12.2 Payment of Prepaid PMPM Rate

In accordance with 42 CFR §438.6(c)(2)(i) the CCN shall be paid in accordance with the prepaid PMPM rates specified in Appendix E – Universal Rate Schedule of this Provider Agreement and updated consistent with the *CCN-P Policy and Procedure Guide*. These rates will be reviewed and adjusted periodically. These rates shall be actuarially sound consistent with requirements set forth in 42 CFR §438.6 (c)(2005, as amended).

12.3 Required Submissions

Prior to execution of this Provider Agreement, the CCN shall submit the DHH Required Submissions documents, as described in the *CCN-P Policy and Procedure Guide*, DHH shall have the right to approve, disapprove or require modification of these documents and any procedures, policies and materials related to the CCN's responsibilities under this Provider Agreement. Upon approval of the Required Submissions, the CCN shall submit a complete copy of all Required Submission documents in a format specified in the *CCN-P Policy and Procedure Guide*. Thereafter, by January 15th of each year, the CCN shall submit, in the aforementioned format, only approved additions, changes and modifications which have been submitted and approved during this year.

12.4 Immunization Data

DHH will enroll all providers in the Louisiana Immunization Network for Kids Statewide (LINKS) web-based immunization reporting system for the reporting of all adult and child vaccinations.

12.5 Notification of Coordinated Care Network Policies and Procedures

CCN agrees to be bound by this Provider Agreement, the guide and any applicable rules or regulations published by DHH. DHH will provide the CCN with updates to appendices, information and interpretation of all pertinent federal and state Medicaid regulations, CCN policies, procedures and guidelines affecting the provision of services under this Provider Agreement. The CCN will submit written requests to DHH for additional clarification, interpretation or other information in a grid format specified by DHH. Provision of such information does not relieve the CCN of its obligation to keep informed of applicable federal and state laws related to its obligations under this Provider Agreement.

12.6 Provider Participation

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 at: <http://www.npdb-hipdb.hrsa.gov/index.html>.

CCNs shall also check the Excluded Parties List System website at www.EPLS.gov and the Office of Inspector General Exclusion Database website at <http://exclusions.oig.hhs.gov/search.aspx> for excluded providers.

12.7 Quality Assessment and Monitoring Activities

DHH will monitor the CCN's performance to assure the CCN is in compliance with the Provider Agreement provisions and the *CCN-P Policy and Procedure Guide*. However this does not relieve the CCN of its responsibility to continuously monitor its provider's performance in compliance with the Provider Agreement provisions and the *CCN-P Policy and Procedure Guide*.

DHH or its designee shall coordinate with the CCN to establish the scope of review, the review site, relevant time frames for obtaining information, and the criteria for review.

DHH or its designee will, at a minimum annually, monitor the operation of the CCN for compliance with the provisions of this Provider Agreement, the *CCN-P Policy and Procedure Guide*, and applicable federal and state laws and regulations. Inspection shall include the CCN's facilities, as well as auditing and/or review of all records developed under this Provider Agreement including, but not limited to, periodic medical audits, grievances, enrollments, disenrollment, termination, utilization and financial records, review of the management systems and procedures developed under this Provider Agreement

and any other areas or materials relevant or pertaining to this Provider Agreement.

The CCN shall have the right to review any of the findings and recommendations resulting from Provider Agreement monitoring and audits, except in the cases of fraud investigations or criminal action. However, once DHH finalizes the results of monitoring and/or audit report, the CCN must comply with all recommendations resulting from the review. Failure to comply with recommendations for improvement may result in monetary penalties, sanctions and/or enrollment restrictions.

12.7.1 Fee-for-Service Reporting to CCNs

The DHH will be responsible for providing CCNs with a recent retrospective fee-for-service history on all current members, if available. This history will go back a maximum of twenty-four (24) months from the month of initial plan membership. DHH's FI will post 820 files (HIPPA format equivalent for the CP-O-92) that the CCN will be able to download. The FI will keep twenty-four (24) months of rolling history available on this website. There will be NO printing/ mailing of any claims history over twenty-four (24) months.

12.7.2 Request for Corrective Action Plan

The DHH will monitor the CCN's quality care outcome activities and corrective actions taken as specified in the CCN Quality Assessment Plan in the *CCN-P Policy and Procedure Guide*.

The CCN must make provisions for prompt response to any detected deficiencies or Provider Agreement violations and for the development of corrective action initiatives relating to this Provider Agreement.

12.7.3 External Quality Review

The DHH will perform periodic medical audits through contractual arrangements to determine if the CCN furnished quality and accessible health care to CCN members as described by 42 CFR §438.358. DHH may establish a contract with an External Quality Review Organization (EQRO) to perform the periodic medical audits and external independent reviews. The *CCN-P Policy and Procedure Guide* lists DHH external quality assessment evaluation requirements.

12.8 Marketing

DHH, and/or its designee shall have the right to approve, disapprove or require modification of all marketing plans, materials, and activities, enrollment and member handbook materials developed by the CCN under this Provider Agreement and prior to implementation and/or distribution by the CCN. See § 7 of this Provider Agreement and the *CCN-P Policy and Procedure Guide* for guidance.

12.9 Grievances/Appeals

DHH shall have the right to approve, disapprove or require modification of all grievance procedures submitted with this Provider Agreement. DHH requires the CCN to meet and/or exceed the CCN grievance standards as outlined in §9 of this Provider Agreement.

12.10 Training

DHH will conduct provider training and workshops on Coordinated Care Program policy and procedures as deemed appropriate for CCNs.

12.11 Federal Fund Restrictions

The CCN is responsible to review DHH's website regarding individuals prohibited from receiving Federal funds that do not appear on the Office of Inspector General (OIG) electronic database but are excluded or suspended from participation in Louisiana Medicaid.

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13 SANCTIONS AND DISPUTE RESOLUTION

13.1 Administrative Action

It is agreed by DHH and the CCN that in the event of the CCN's failure to meet the requirements provided in this Provider Agreement, *CCN-P Policy and Procedure Guide, Systems Companion Guide and Quality Performance Measure Companion Guide*, DHH has the right to impose administrative actions/sanctions against the CCN as defined in this Provider Agreement and *CCN-P Policy and Procedure Guide*. It shall be at DHH's sole discretion as to the proper administrative sanction that will be imposed.

13.2 Corrective Action Plan (Provider Agreement Non-Compliance)

DHH will notify the CCN through Notice of Corrective Action when DHH or its designee determines that the CCN is deficient or non-compliant with requirements (excluding causes for intermediate sanctions and termination) of the Provider Agreement. The determination of deficiency and/or non-compliance with such requirements is at the sole discretion of DHH. The CCN shall submit a corrective action plan (CAP) to DHH, within the timeframe specified in the notice, for approval. The CAP shall delineate the steps and timeline for correcting deficiencies and/or non-compliance issues identified in the notice.

DHH shall impose monetary penalties and/or sanctions on the CCN for a deficient CAP. A CAP is deficient when not submitted within the Notice of Corrective Action timeline requirements; does not adequately address deficiency; and/or when the CCN and/or its contractor(s) fail to implement and/or follow the CAP.

13.3 Sanctions

13.3.1 Table of Monetary Penalties

DHH may impose monetary penalties upon the CCN for failure to timely and accurately comply with the reporting requirements and for deficient deliverables under this Provider Agreement and the *CCN-P Policy and Procedure Guide*.

For each day that each deliverable is late, incorrect or deficient, the CCN may be liable to DHH for monetary penalties in an amount per calendar day per deliverable as specified in the table below. Monetary penalties have been designed to escalate by duration and by occurrence over the term of this Provider Agreement.

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Occurrence	Daily Amount for Days 1-14	Daily Amount for Days 15-30	Daily Amount for Days 31-60	Daily Amount for Days 61 and Beyond
1-3	\$ 750	\$ 1,200	\$ 2,000	\$ 3,000
4-6	\$ 1,000	\$ 1,500	\$ 3,000	\$ 5,000
7-9	\$ 1,500	\$ 2,000	\$ 4,000	\$ 6,000
10-12	\$ 1,750	\$ 3,500	\$ 5,000	\$ 7,500
13 and Beyond	\$ 2,000	\$ 4,000	\$ 7,500	\$10,000

DHH shall utilize the following guidelines to determine whether a report is correct and complete:

1. The report must contain 100% of the CCN's data;
2. 99% of the required items for the report must be completed; and
3. 99.5% of the data for the report must be accurate as determined by edit specifications/review guidelines set forth by DHH.

Monetary penalties for late reports or deliverables shall begin on the first day the report is late. Monetary penalties for incorrect reports/deliverables shall begin on the sixteenth (16th) day after notice provided to the CCN that reports are incorrect or deliverables are insufficient. For the purposes of determining monetary penalties in accordance with this section, reports or deliverables are due in accordance with the following schedule:

13.3.2 Monetary Penalties

In addition to the monetary penalties/fines provided in the Balance Budget Act of 1997 (P.L. 105-33), DHH may impose fines on the CCN in the amounts listed below for the following:

13.3.2.1 Key Personnel

- 13.3.2.1.1** Seven hundred dollars (\$ 700.00) per calendar day for failure to have a full-time acting or permanent Project Director for more than seven (7) consecutive calendar days for each day following the seventh (7th) day the Project Director has not been appointed.

13.3.2.1.2 Seven hundred dollars (\$ 700.00) per calendar day for failure to have a full-time acting or permanent medical director for more than seven (7) consecutive calendar days for each day following the seventh (7th) day the medical director has not been appointed.

13.3.2.1.3 Failure of the CCN to appoint a permanent full-time Project Director or medical director as specified in Section 3 - *CCN Administrative Management Section of the Provider Agreement*, within forty-five days after the position(s) becomes vacant shall result in withholding one (1) percent of the CCN's PMPM payments for each thirty (30) days the positions are vacant.

13.3.2.2 Member Services Activities

13.3.2.2.1 Five thousand dollars (\$ 5,000.00) per calendar day for failure to provide access to primary care providers that offer extended office hours (minimum of 2 hours) at least one day per week (after 5:00 pm Central Time) and on Saturdays [up to four (4) hours] Section 3 - *CCN Provider Network Requirement - Hours of Operation in the CCN-P Policy and Procedure Guide*.

13.3.3.2.2 Five thousand dollars (\$ 5,000.00) per calendar day for failure to provide member service functions during from 7 a.m. to 7 p.m. Central Standard Time Monday through Friday, to address non-emergency issues encountered by members, and 24 hours a day/7 days a week to address emergency issues encountered by members as specified in Section 3- *CCN Provider Network Requirement - Hours of Operation in the CCN-P Policy and Procedure Guide*.

13.3.2.3 Provider Services Activities

13.3.2.3.1 Five thousand dollars (\$ 5,000.00) per calendar day for failure to provide for arrangements to handle emergent provider issues on a twenty-four (24) hour, seven (7) day-a-week basis as defined in Section 3 - *CCN Provider Network Requirement - Hours of Operation in the CCN-P Policy and Procedure Guide*.

13.3.2.3.2 Five thousand dollars (\$ 5,000.00) per calendar day for failure to furnish provider service functions from 7 a.m. to 7 p.m. Central Time Monday through Friday to address non-emergency issues encountered by providers, as specified in Section 3 - *CCN Provider Network Requirements - Provider Relation Services* in the *CCN-P Policy and Procedure Guide*.

13.3.2.4 Encounter Data

13.3.2.4.1 Ten thousand dollars (\$ 10,000.00) per calendar day for each day after the due date that the monthly encounter data has not been received in the format and per specifications outlined in Section 16 - *System and Technical Requirements* in the *CCN-P Policy and Procedure Guide*.

13.3.2.4.2 Ten thousand dollars (\$ 10,000.00) per calendar day for each day encounter data is received after the due date, for failure to correct and resubmit encounter data that was originally returned to the CCN for correction because submission data was in excess of the five (5) percent error rate threshold, until acceptance of the data by the fiscal intermediary.

13.3.2.4.3 Ten thousand dollars (\$ 10,000.00) per return by the fiscal intermediary of re-submission of encounter data that was returned to the CCN, as submission data was in excess of the five (5) percent error rate threshold, for correction and was rejected for the second time.

13.3.2.4.4 Ten thousand dollars (\$ 10,000.00) per occurrence of medical record review by DHH or its designee where the CCN or its provider(s) denotes provision of services which were not submitted in the encounter data regardless of whether or not the provider was paid for the service that was documented.

13.3.2.4.5 Five thousand dollars (\$5,000.00) per calendar day after the ninetieth (90th) day for failure to submit encounter data within ninety (90) days of payment for a claim/bill for services(s).

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Penalties specified above shall not apply for encounter data for the first three months after direct services to CCN members have begun to permit time for development and implementation of a system for exchanging data and training of staff and health care providers.

13.3.2.5 Timely Deliverables and Reports

- 13.3.2.5.1** Two thousand dollars (\$2,000.00) per report for each calendar day the Quality Assessment and Performance Improvement Plan (QAPI), performance measure, and/or performance improvement project reports are late or incorrect as outlined in the Provider Agreement, this *Guide* and *Quality Companion Guide*.
- 13.3.2.5.2** Two thousand dollars (\$2,000.00) per calendar day for each calendar day the member and/or provider satisfaction reports are late or incorrect as outlined in the Provider Agreement and in the *CCN-P Policy and Procedure Guide*.
- 13.3.2.5.3** Two thousand dollars (\$2,000.00) per calendar day for each business day any other data as required by the Provider Agreement, or upon request by DHH and mutually agreed upon by the CCN, is late or incorrect.
- 13.3.2.5.4** One thousand dollars (\$1,000.00) per calendar day for each day the Patient Center Medical Home Plan as specified in Section 3 - *CCN Provider Network Requirements* in the *CCN-P Policy and Procedure Guide* is received after the due date.

Deliverables	Date Due
Daily Report	Within two (2) business days.
Weekly Reports	Wednesday of the following week.
Monthly Reports	15 th of the following month with the exception of certain reports and due dates specified in the <i>CCN-P Policy and Procedure Guide</i>

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Deliverables	Date Due
Annual Reports	Ninety (90) calendar days after the end of the year.
On Request/ Additional Reports	Within three (3) business days from the date of request unless otherwise specified by DHH.
Encounter data - 95% accurate Submission	Ninety (90) calendar days after the date of initial submission.
Employment of licensed personnel	\$250.00 per calendar day for each day that personnel are not licensed as required by applicable state and federal laws and/or regulations. See also §3.1.2 of this Provider Agreement.
Employment of Key Personnel	\$700.00 per calendar day for failure to have a full-time acting or permanent Project Director for more than seven (7) consecutive calendar days for each day the Project Director has not been appointed; \$ 700.00 per calendar day for failure to have a full-time acting or permanent medical director for more than seven (7) consecutive calendar days for each day the medical director has not been appointed.

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Deliverables	Date Due
Corrective Action Plans	\$10,000.00 per calendar day for each day submitted following the due date; \$10,000.00 per calendar day for each day the CAP is returned as disapproved from DHH. Up to \$10,000.00 per calendar day for each day the corrective action is not completed in accordance with the timeline established in the Corrective Action Plan.
Late, incorrect or deficient reports, including, but not limited to HEDIS reports, Encounter data initial submission, and CRCS reports.	Amount per calendar day specified in table in § 13.3.1 above for each file or report or as specified in this Provider Agreement.
Encounter Data – failure to meet 100% accurate submission deadline as set forth in §10.4	\$10,000 per calendar day.

13.3.2.6 Emergency Management Plan Submission

Ten thousand dollars (\$10,000.00) per calendar day for each day the Emergency Management Plan as specified in Section 14.38 – *Terms and Conditions* in the Provider Agreement and as specified in the *CCN-P Policy and Procedure Guide* is received after the due date or up to one hundred thousand dollars (\$100,000) for failure to submit timely. However DHH may sanction an additional two hundred thousand dollars (\$200,000) for failure to submit the plan prior to the beginning of the Atlantic hurricane season (June 1st).

13.3.2.7 Additional Monetary Penalties

In accordance with 42 CFR §438.704, DHH may impose the following monetary penalties:

13.3.2.7.1 Twenty-five thousand dollars (\$25,000.00) for exceeding ten percent (10%) member appeals over a twelve month period which have been overturned in a State Fair Hearing; or for each occurrence in which the CCN does not provide the medical services or

requirements set forth in the final outcome of the administrative decision by DHH or the appeals decision of the State Fair Hearing. This penalty is in addition to the cost the CCN shall reimburse DHH for the provision of the medical service or requirement not provided by the CCN.

13.3.2.7.2 For a **nonwillful violation** as determined by DHH, the fine shall not exceed twenty-five hundred dollars (\$2,500.00) per violation and shall not exceed an aggregate of ten thousand dollars (\$10,000.00) for all nonwillful violations arising out of the same action.

13.3.2.7.3 For a **willful violation** as determined by DHH, DHH may impose a fine not to exceed twenty thousand dollars (\$20,000.00) for each violation not to exceed an aggregate of one hundred thousand dollars (\$100,000.00) for all knowing and willful violations arising out of the same action.

13.3.2.7.4 For purposes of this section, violations including individual, unrelated enrollees shall **not** be considered arising out of the same action.

Any monetary penalties assessed by DHH that cannot be collected through withholding from future PMPM payments shall be due and payable to DHH within thirty (30) calendar days after CCN receipt of the notice of monetary penalties. However, in the event an appeal by the CCN results in a decision in favor of the CCN, any such funds withheld by DHH will be returned to the CCN.

Whenever monetary penalties for a single occurrence exceed \$25,000.00, CCN staff will meet with DHH staff to discuss the causes for the occurrence and to negotiate a reasonable plan for corrective action of the occurrence. Once a corrective action plan has been approved by DHH, collection of monetary penalties during the agreed upon corrective action period will be suspended. The corrective action plan must include a date certain for the correction of the occurrence. Should that date for correction be missed by the CCN, the original schedule of monetary penalties will be reinstated, including collection of monetary penalties for the corrective action period, and monetary

penalties will continue until satisfactory correction as determined by DHH of the occurrence has been made.

At DHH's sole discretion, based on identified facts and documentation, if DHH determines that the CCN is failing to meet material obligations and performance standards described in this Provider Agreement, it may suspend CCN's right to enroll new members and impose any other sanctions in accordance with §13 of this Provider Agreement. The DHH, when exercising this option, shall notify CCN in writing of its intent to suspend new enrollment. The suspension period may be for any length of time specified by DHH, or may be indefinite. The DHH also may notify members of the CCN of any alleged non-performance and permit these members to transfer to another CCN following the implementation of suspension.

13.3.3 Intermediate Sanctions

If DHH determines that the CCN has violated any provision of this Provider Agreement, or the applicable statutes or rules governing Medicaid risk-bearing CCNs, the DHH may impose sanctions against the CCN. DHH shall notify the CCN and CMS in writing of its intent to impose sanctions and explain the process for CCN to employ the dispute resolution process as described in this Provider Agreement. Sanctions shall be in accordance with §1932 of the Social Security Act (42 U.S.C. §1396u-2) and 42 CFR §§438.700-730 and may include any of the following:

- 13.3.3.1** Suspension of payment for CCN members enrolled after the effective date of the sanction and until CMS and/or DHH is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. This violation may result in recoupment of the prepaid PMPM payment;
- 13.3.3.2** Imposition of a fine of up to Twenty-five Thousand Dollars (\$25,000.00) for each marketing/enrollment violation, in connection with any one audit or investigation;
- 13.3.3.3** Termination pursuant to §13.3.4 of this Provider Agreement;
- 13.3.3.4** Non-renewal of the Provider Agreement pursuant to §14.2 of this Provider Agreement;
- 13.3.3.5** Suspension of automatic assignments;

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- 13.3.3.6** Appointment of temporary management in accordance with § 1932(e)(2)(B) of SSA (42 U.S.C. 1396u-2) (2001, as amended) and 42 CFR §438.706. If the State finds that the CCN has repeatedly failed to meet substantive requirements in §1903(m) or §1932 of the Social Security Act (42 USC 1396u-2), the State must impose temporary management, grant members the right to terminate enrollment without cause and notify the affected members of their right to terminate enrollment;
- 13.3.3.7** Civil money penalties in accordance with §1932 of the Social Security Act (42USC 1396u-2);
- 13.3.3.8** Withhold up to thirty percent (30%) of a CCN's monthly PMPM payment;
- 13.3.3.9** Permit individuals enrolled in the CCN to disenroll without cause. DHH may suspend or default all enrollment of Medicaid/CHIP eligibles after the date the CMS or DHH notifies the CCN of an occurrence under §1903(m) or § 1932(e).of the Social Security Act;
- 13.3.3.10** Terminate the Provider Agreement if the CCN has failed to meet the requirements of sections 1903(m), 1905(t)(3) or 1932(e) of the Social Security Act and offer the CCN's Medicaid members an opportunity to enroll with other CCNs to allow members to receive medical assistance under the State Plan. DHH shall provide the CCN a dispute resolution conference before the DHH Undersecretary before termination occurs. This is the exclusive remedy and the Administrative Procedure Act does not apply. DHH will notify the Medicaid members enrolled in the CCN of the conference and allow the Medicaid members to disenroll, if they choose, without cause;
- 13.3.3.11** Imposition of sanctions pursuant to § 1932(e)(B) of the Social Security Act if the CCN does not provide abortion services as provided under the Provider Agreement at **§4.6**;
- 13.3.3.12** Imposition of a fine of up to twenty-five thousand dollars (\$25,000.00) for each occurrence of the CCN's failure to substantially provide medically necessary items and services that are required to be provided to a member covered under the Provider Agreement;

- 13.3.3.13** Imposition of a fine of up to fifteen thousand dollars (\$15,000.00) per individual not enrolled and up to a total of one hundred thousand dollars (\$100,000.00) per each occurrence, when the CCN acts to discriminate among members on the basis of their health status or their requirements for health care services. Such discrimination includes, but is not limited to, expulsion or refusal to re-enroll an individual, except as permitted by Title XIX, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the entity by eligible individuals whose medical condition or history indicates a need for substantial future medical services;
- 13.3.3.14** Imposition of a fine of up to twenty-five thousand dollars (\$25,000.00) or double the amount of the excess charges, (whichever is greater) for charging premiums or charges in excess of the amounts permitted under the Medicaid program. DHH will deduct from the penalty the amount of overcharges and return it to the affected member(s).
- 13.3.3.15** Imposition of sanctions as outlined above if the CCN misrepresents or falsifies information that it furnishes to CMS, to the State or to a member, potential member or health care provider.
- 13.3.3.16** Imposition of sanctions as outlined in the *CCN-P Policy and Procedure Guide* if the CCN fails to comply with the Physician Incentive Plan requirements or other sanctions set forth in the *CCN-P Policy and Procedure Guide*.

Unless the duration of a sanction is specified, a sanction will remain in effect until DHH is satisfied that the basis for imposing the sanction has been corrected. DHH will notify CMS when a sanction has been lifted.

13.3.4 Violations Subject to Intermediate Sanctions

The following are non-exhaustive grounds for which intermediate sanctions may be imposed when a CCN acts or fails to act:

- 13.3.4.1** Fails substantially to provide medically necessary services that the CCN is required to provide, under law or under this Provider Agreement, to a member covered under the Provider Agreement;

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- 13.3.4.2 Imposes on member's premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;
- 13.3.4.3 Acts to discriminate among enrollees on the basis of their health status or need for health care services;
- 13.3.4.4 Misrepresents or falsifies information that it furnishes to CMS or to DHH;
- 13.3.4.5 Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider;
- 13.3.4.6 Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR §§422.208 and 422.210;
- 13.3.4.7 Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by DHH or that contain false or materially misleading information; and
- 13.3.4.8 Has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.

13.3.5 Termination for Cause

13.3.5.1 Issuance of Notice of Termination

DHH may terminate the Provider Agreement when DHH determines the CCN and/or CCN contractor(s) have failed to perform, or violates, substantive terms of the Provider Agreement and the *CCN-P Policy and Procedure Guide*; and fails to meet applicable requirements in sections 1932, 1903(m), 1905(t) of the Act.

DHH will provide the CCN with a timely written *Notice of Intent to Terminate (Notice)*. In accordance with 42 CFR §438.708, the *Notice* will state the nature and basis of the sanction, pre-termination hearing and dispute resolution conference rights, and the time and place of the hearing. The termination will be effective no less than thirty (30) calendar days from the date of the *Notice*. The CCN may, at the

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discretion of DHH, be allowed to correct the deficiencies within the thirty (30) calendar day notice period, unless other provisions in this section demand otherwise, prior to the issue of a Notice of Termination.

13.3.5.1.1 In accordance with 42 CFR §438.708, DHH will conduct a pre-termination hearing as outlined in the *Notice* to provide CCN the opportunity to contest the nature and basis of the sanction. The CCN may request a pre-termination hearing with the DHH Deputy Medicaid Director and/or a dispute resolution conference before the DHH Undersecretary prior to the determined date of termination stated in the *Notice*.

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

13.3.5.1.3 The decision by the DHH Undersecretary is the exclusive remedy and LA R.S. 49:950-999.25, the Administrative Procedure Act, does not apply.

13.3.5.1.4 Notice of Termination will state the effective date of termination.

13.3.5.1.5 DHH will notify the Medicaid members enrolled in the CCN, consistent with 438.10, of the affirming termination decision and options for receiving Medicaid services and initiate reenrollment process.

13.3.5.2 Termination Due to Serious Threat to Health of Members

DHH may terminate this Provider Agreement immediately if it is determined that actions by the CCN or its contractor(s) pose a serious threat to the health of members enrolled in the CCN. The CCN members will be given an opportunity to enroll in another CCN (if there is capacity) or move to fee-for-service.

13.3.5.3 Payment of Outstanding Monies or Collections from CCN

The CCN will be paid for any outstanding monies due less any assessed monetary penalties. If monetary penalties exceed monies due, collection can be made from the CCN Fidelity Bond, Errors and Omissions Insurance, or any insurance policy or policies required under this Provider Agreement. The rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Provider Agreement.

13.3.5.4 Termination for CCN Insolvency, Bankruptcy, Instability of Funds

The CCN's insolvency or the filing of a petition in bankruptcy by or against the CCN shall constitute grounds for termination for cause. If DHH determines the CCN has become financially unstable, DHH will immediately terminate this Provider Agreement upon written notice to the CCN effective the close of business on the date specified.

13.3.4.4.1 Continue Services during Insolvency

The CCN shall cover continuation of services to members for the duration of any period for which payment has been made, as well as for inpatient admissions up until discharge.

13.3.5.5 Termination for Ownership Violations

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

13.3.5.5.1 A person with a direct or indirect ownership interest in the CCN

- 1) Has been convicted of a criminal offense under §§1128(a) and 1128(b)(1), or (3) of the Social Security Act, in accordance with 42 CFR §1002.203;
- 2) Has had civil monetary penalties or assessment imposed under § 1128A of the Act; or
- 3) Has been excluded from participation in Medicare or any State health care program;

and

- 4) Any individual that has a direct or indirect ownership interest or any combination thereof of 5% or more, is an officer if the CCN is organized as a corporation or a partner, if it is organized as a partnership, or is an agent or a managing employee, have one of the conditions specified in 1) - 3) above.

13.3.5.5.2 The CCN has a direct or indirect substantial contractual relationship with an excluded individual or entity. "Substantial contractual relationship" is defined as any direct or indirect business transactions that amount in a single fiscal year to more than \$25,000 or 5% of the CCN's total operating expenses, whichever is less.

13.3.5.6 Termination Due to Conversion from CCN-S Provider Type to CCN-P Provider Type

13.3.5.6.1 After a minimum of twelve months of provision of services, the CCN may terminate this Provider Agreement for cause when the CCN declares that it will convert from a CCN - Shared Savings provider type to a CCN-Prepaid provider type.

13.3.5.6.2 The CCN must provide 120 notice to DHH of such intent and follow the requirements set forth in **§13.3.5.8** below.

13.3.5.6.3 The CCN shall not be subject to the cost specified in **§13.3.5.8.10** below.

13.3.5.7 Termination Due to Conversion from CCN-P Provider Type to CCN-S Provider Type

13.3.5.7.1 After a minimum of twelve months of provision of services, the CCN may

terminate this Provider Agreement for cause if the CCN declares that it will convert from a CCN-Prepaid provider type to a CCN Share- provider type.

- 13.3.5.7.2** The CCN must provide 120 notice to DHH of such intent and follow the requirements set forth in **§13.3.5.8** below.

13.3.5.8 CCN Requirements Prior to Termination for Cause

The CCN shall comply with all terms and conditions stipulated in this Provider Agreement and *CCN-P Policy and Procedure Guide* during the period prior to the effective termination date including:

- 13.3.5.8.1** Continue to provide services under the Provider Agreement, until the termination effective date;

- 13.3.5.8.2** Within ten (10) days of the CCN's written notification to DHH of its intent to terminate its Provider Agreement, submit a termination plan to DHH for review and approval. The CCN shall make revisions to the plan as necessary or as required by DHH and will resubmit the plan to DHH for approval after each revision. Failure to submit a termination plan within ten (10) days of written notification to DHH of termination or to timely resubmit the plan after revisions may, in DHH' discretion, result in a delay of the CCN's planned termination date. Failure to submit a termination plan in the time specified in this provision may result in an withhold of 50% of the CCN's monthly prepaid PMPM payment. These funds will be withheld until DHH receives the termination plan;

- 13.3.5.8.3** Agree to maintain claims processing functions as necessary for a maximum of twelve (12) months in order to complete adjudication of all claims;

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- 13.3.5.8.4** Remain liable and retain responsibility for all claims with dates of service through the day of termination;
- 13.3.5.8.5** Be financially responsible through their date of discharge for patients who are hospitalized prior to the termination date;
- 13.3.5.8.6** Be financially responsible for services rendered prior to the termination date, for which payment is denied by the CCN and subsequently approved upon appeal;
- 13.3.5.8.7** Be financially responsible for member appeals of adverse decisions rendered by the CCN concerning treatment requested prior to the termination date which are subsequently determined in the member's favor after an appeal proceeding or a State Fair Hearing;
- 13.3.5.8.8** Assist DHH with grievances and appeals for dates of services prior to the termination date;
- 13.3.5.8.9** Arrange for the orderly transfer of patient care and patient records to those providers who will assume members' care. For those members in a course of treatment for which a change of providers could be harmful, the CCN must continue to provide services until that treatment is concluded or appropriate transfer of care can be arranged;
- 13.3.5.8.10** Notify all members in writing about the Provider Agreement termination and the process by which members will continue to receive medical care at least 60 calendar days in advance of the effective date of termination. The CCN will be responsible for all expenses associated with member notification. DHH must approve all

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member notification materials in advance of distribution. Such notice must include a description of alternatives available for obtaining services after Provider Agreement termination;

13.3.5.8.11 Notify all of its providers in writing about the Provider Agreement termination at least 60 calendar days in advance of the effective date of termination. The CCN will be responsible for all expenses associated with provider notification. DHH must approve all provider notification materials in advance of distribution;

13.3.5.8.12 File all reports concerning the CCN's operations during the term of the Provider Agreement in the manner described in this Provider Agreement;

13.3.5.8.13 Take all actions necessary to ensure the efficient and orderly transition of participants from coverage under this Provider Agreement to coverage under any new arrangement authorized by DHH;

13.3.5.8.14 To ensure fulfillment of its obligations before and after termination, maintain the financial requirements, fidelity bonds and insurance set forth in this Provider Agreement until DHH provides the CCN written notice that all obligations of this Provider Agreement have been met;

13.3.5.8.15 Submit reports to DHH every thirty (30) calendar days detailing the CCN's progress in completing its obligations under this Provider Agreement after the termination date. The CCN, upon completion of these obligations, shall submit a final report to DHH describing how the CCN has completed its obligations. DHH shall, within twenty (20) calendar days of receipt of this report, advise in writing whether it

agrees that the CCN has met its obligations. If DHH does not agree, then the CCN shall complete the necessary tasks and submit a revised final report. This process shall continue until DHH approves the final report;

13.3.5.8.16 Take whatever other actions are required by DHH to complete this transition;

13.3.5.8.17 Be responsible for all financial costs associated with its termination, including but not limited to costs associated with changes to the enrollment broker's website and computer system and mailings by the enrollment broker to the CCN's members regarding their choice period after the termination effective date;

13.3.5.8.18 If applicable, assign to DHH in the manner and extent directed by DHH all the rights, title and interest of the CCN for the performance of the contracts to be determined as needed in which case DHH shall have the right, in its discretion, to resolve or pay any of the claims arising out of the termination of such agreements and contracts. The CCN shall supply all information necessary for the reimbursement of any outstanding Medicaid claims. In the event contracts are not assignable to DHH's satisfaction, the CCN shall remain fully liable for all obligations, financial or otherwise, in the Provider Agreement. In this case, DHH may utilize funds from any applicable bonds in its discretion;

13.3.5.8.19 Complete the performance of such part of the Provider Agreement which shall have not been terminated under the notice of termination;

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13.3.5.8.20 Take such action as may be necessary, or as DHH may direct, for the protection of property related to this Provider Agreement which is in possession of the CCN in which DHH has or may acquire an interest;

13.3.5.8.21 In the event the Provider Agreement is terminated by DHH, continue to serve or arrange for provision of services to the members of the CCN until the effective date of termination. During this transition period, DHH shall continue to pay the applicable PMPM rate(s). Members shall be given written notice of the State's intent to terminate the Provider Agreement and shall be allowed to disenroll immediately without cause;

13.3.5.8.22 Provide all necessary assistance to DHH in transitioning members out of the CCN's plan to the extent specified in the notice of termination. Such assistance shall include, but not be limited to, the forwarding of all medical or financial records related to the CCN's activities undertaken pursuant to this Provider Agreement; facilitation and scheduling of medically necessary appointments for care and services; and identification of chronically ill, high risk, hospitalized, and pregnant members in their last four (4) weeks of pregnancy; and

The transitioning of records, whether medical or financial, related to the CCN's activities undertaken pursuant to this Provider Agreement shall be in a form usable by DHH or any party acting on behalf of DHH and shall be provided at no expense to DHH or another CCN acting on behalf of DHH.

13.3.5.8.23 Promptly supply all information necessary to DHH or its designee of any outstanding claims at the time of termination;

Once DHH receives the notice of termination, DHH shall:

- a. Stop auto-assignment of members to the terminating plan as of the date written notification of termination is received by DHH.
- b. Review, revise and approve the CCN's termination plan and final report in accordance with the procedures outlined above.
- c. Review, revise and approve all correspondence to the CCN's members and providers prior to distribution.
- d. Cease all new member enrollments in the CCN's plan at such time as determined by DHH. This decision shall be at the sole discretion of DHH.

Any of the above-stated requirements may be waived or altered upon written request by the CCN and written approval by DHH.

13.3.6 Other Sanctions

DHH may impose additional sanctions allowed under state statute or regulation that address areas of noncompliance, Unless the duration of a sanction is specified, a sanction will remain in effect until DHH is satisfied that the basis for imposing the sanction has been corrected. DHH will notify CMS when a sanction has been lifted.

13.3.7 Sanction by CMS: Special Rules for MCOs and Denial of Payment

Payments provided for under this Provider Agreement will be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in 42 CFR §438.730.

13.3.8 Special Rules for Temporary Management

13.3.8.1 Temporary management may only be imposed by DHH if:

- a. There is continued egregious behavior by the CCN, including, but not limited to behavior that is described in 42 CFR §438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Act; or
- b. There is substantial risk to member's health; or
- c. The sanction is necessary to ensure the health of the CCN's members while improvements are made to remedy violations under 42 CFR §438.700 or until there is an orderly termination or reorganization of the CCN.

13.3.8.2 DHH may impose temporary management if it finds that the CCN has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Act. DHH shall grant members the right to terminate enrollment without cause and will notify the affected members of their right to terminate enrollment. DHH will not delay imposition of temporary management to provide a hearing before imposing this sanction. In addition, the DHH will not terminate temporary management until it determines that the CCN can ensure that the sanctioned behavior will not recur.

13.4 Dispute Resolutions

The CCN shall have the right to dispute resolution through DHH pursuant to LA R.S. 46:107 if they are providing service, under the provisions of Titles XIX and XXI of the Social Security Act and are aggrieved by the agency action resulting in the denial, suspension or revocation of a license or the refusal to enter into, suspension of, or termination of a service agreement, or if DHH takes any action against the CCN.

For dispute resolution request related to sanctions, except for termination for cause §13.3.4, the CCN shall comply with the procedures outlined in this section and the *CCN-P Policy and Procedure Guide*.

The CCN may submit a written request for a hearing with the Medicaid Deputy Director over the Medicaid Coordinated Care Section; and/or a dispute resolution conference before the DHH Undersecretary to dispute the nature and basis of the sanction prior to effective sanction date stated in the notice of intent to sanction.

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The CCN shall receive a written notice of the outcome of the hearing and/or dispute resolution conference, indicating decision reversal or affirmation.

The decision by the DHH Undersecretary is the exclusive remedy and the Administrative Procedure Act does not apply.

Effective dates of affirmed sanction will be delineated in the notice subsequent to the final determination.

In the event the CCN challenges the decision of the DHH Undersecretary, the DHH action shall not be stayed except by order of the court.

Pending final determination of any dispute over a DHH decision, the CCN shall proceed diligently with the performance of the Provider Agreement and in accordance with the direction of DHH.

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14 TERMS AND CONDITIONS

The CCN agrees to comply with all state and federal laws, regulations, and policies as they exist or as amended that are or may be applicable to this Provider Agreement, including those not specifically mentioned in this section. Any provision of this Provider Agreement which is in conflict with federal statutes, regulations, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and federal policy. Such amendment of the Provider Agreement will be effective on the effective date of the statutes, regulations, or policy statement necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties. The CCN may request DHH to make policy determinations required for proper performance of the services under this Provider Agreement.

14.1 Applicable Laws and Regulations

The CCN agrees to comply with all applicable federal and state laws and regulations including Constitutional provisions regarding due process and equal protection under the laws and including but not limited to:

- 14.1.1** Title 42 Code of Federal Regulations (CFR) Chapter IV, Subchapter C (Medical Assistance Programs);
- 14.1.2** All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. 7401, et seq.) and 20 USC §6082(2) of the Pro-Children Act of 1994, as amended (P.L. 103-227);
- 14.1.3** Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. 2000d) and regulations issued pursuant thereto, 45 CFR part 80; In accordance with Title VI of the Civil Rights Act of 1964 (42U.S.C. 2000d et seq.) and its implementing regulation at 45 CFR Part 80, the Provider 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 this agreement.
- 14.1.4** Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. 2000e) in regard to employees or applicants for employment;
- 14.1.5** Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 CFR Part 84;

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- 14.1.6 The Age Discrimination Act of 1975, as amended, 42 U.S.C 6101 et seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance;
- 14.1.7 The Omnibus Budget Reconciliation Act of 1981, as amended, P.L.E.97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance;
- 14.1.8 The Balanced Budget Act of 1997, as amended, P.L. 105-33 and the Balanced Budget Refinement Act of 1999, as amended, H.R. 3426;
- 14.1.9 Americans with Disabilities Act, as amended, 42 U.S.C. §12101 et seq., and regulations issued pursuant thereto;
- 14.1.10 Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusion of CCNs for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;
- 14.1.11 Drug Free Workplace Acts, S.C. Code Ann. §44-107-10 et seq. (Supp. 2000, as amended), and the Federal Drug Free Workplace Act of 1988 as set forth in 45 CFR Part 82;
- 14.1.12 Title IX of the Education Amendments of 1972 regarding education programs and activities; and
- 14.1.13 Byrd Anti-Lobbying Amendment- Contractors who apply or bid shall file the require certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any federal award. Such disclosures are forwarded form tier to tier up to the recipient (45 CFR Part 3).

14.2 Non-Renewal

This Provider Agreement shall be renewed only upon mutual consent of the parties. Either party may decline to renew the Provider Agreement for any reason.

14.3 Termination Without Cause

The party initiating termination of the Provider Agreement without cause shall submit a written Notice of Intent to Terminate without cause notice to the other party by certified mail, return receipt requested, in accordance with the requirements and timeframes specified in this section. The notice shall specify the provision of this Provider Agreement allowing for termination without cause and the date on which such termination shall become effective. **Termination without cause is not subject to dispute resolution process.** The CCN shall comply with the requirements set forth in this Provider Agreement and the *CCN-P Policy and Procedure Guide*.

14.2.1 Termination under Mutual Agreement

Under mutual agreement, DHH and the CCN may terminate this Provider Agreement without cause if it is in the best interest of DHH and the CCN. Both parties will sign a notice of termination which shall include, the date of termination, conditions of termination, and extent to which performance of work under this Provider Agreement is terminated.

14.3.2 Termination for Convenience

DHH may terminate this Provider Agreement for convenience and without cause upon sixty (60) calendar days written notice. Said termination shall not be a breach of Provider Agreement by DHH and DHH shall not be responsible to the CCN or any other party for any costs, expenses, or damages occasioned by said termination, i.e., without penalty.

14.3.3 Termination for Unavailability of Funds

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

14.2.4 Termination by the CCN

The CCN may terminate the Provider Agreement without cause with no less than one hundred and twenty (120) calendar days advance notice to DHH. The CCN shall submit a written *Notice of Intent to Terminate* this Provider Agreement without cause to DHH by certified mail, return receipt requested. The one hundred and twenty (120) calendar day

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advance notice timeframe and the effective termination date of the Provider Agreement will be one hundred and twenty (120) calendar days following the date DHH receives the notice.

The CCN shall comply with all terms and conditions stipulated in this Provider Agreement during the period prior to the Provider Agreement termination effective date including:

- 14.3.4.1** Continue to provide services under the Provider Agreement, until the termination effective date;
- 14.3.4.2** Within ten (10) days of the CCN's written notification to DHH of its intent to terminate its Provider Agreement, submit a termination plan to DHH for review and approval. The CCN shall make revisions to the plan as necessary or as required by DHH and will resubmit the plan to DHH for approval after each revision. Failure to submit a termination plan within ten (10) days of written notification to DHH of termination or to timely resubmit the plan after revisions may, in DHH' discretion, result in a delay of the CCN's planned termination date. Failure to submit a termination plan in the time specified in this provision shall result in a withhold of 25% of the CCN's monthly prepaid enhanced care management fee payments. These funds will be withheld until DHH receives the termination plan;
- 14.3.4.3** Assist DHH with grievances and appeals for dates of services prior to the termination date;
- 14.3.4.4** Arrange for the orderly transfer of patient care and patient records to those providers who will assume members' care. For those members in a course of treatment for which a change of providers could be harmful, the CCN must continue to provide services until that treatment is concluded or appropriate transfer of care can be arranged;
- 14.3.4.5** Notify all members in writing about the Provider Agreement termination and the process by which members will continue to receive primary care services and care management at least 60 calendar days in advance of the effective date of termination. The CCN will be responsible for all expenses associated with member notification. DHH must approve all member notification materials in advance of distribution. Such notice must include a description of

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- alternatives available for obtaining services after Provider Agreement termination;
- 14.3.4.6** Notify all of its providers in writing about the Provider Agreement termination at least 60 calendar days in advance of the effective date of termination. The CCN will be responsible for all expenses associated with provider notification. DHH must approve all provider notification materials in advance of distribution;
- 14.3.4.7** File all reports concerning the CCN's operations during the term of the Provider Agreement in the manner described in this Provider Agreement;
- 14.3.4.8** Take all actions necessary to ensure the efficient and orderly transition of participants from coverage under this Provider Agreement to coverage under any new arrangement authorized by DHH;
- 14.3.4.9** Ensure fulfillment of its obligations before and after termination, maintain the financial requirements, fidelity bonds and insurance set forth in this Provider Agreement until DHH provides the CCN written notice that all obligations of this Provider Agreement have been met;
- 14.3.4.10** Submit reports to DHH every thirty (30) calendar days detailing the CCN's progress in completing its obligations under this Provider Agreement after the termination date. The CCN, upon completion of these obligations, shall submit a final report to DHH describing how the CCN has completed its obligations. DHH shall, within twenty (20) calendar days of receipt of this report, advise in writing whether it agrees that the CCN has met its obligations. If DHH does not agree, then the CCN shall complete the necessary tasks and submit a revised final report. This process shall continue until DHH approves the final report;
- 14.3.4.11** Take whatever other actions are required by DHH to complete this transition;
- 14.3.4.12** Be responsible for all financial costs associated with its termination, including but not limited to costs associated with cost to DHH for re-enrollment activities including the changes to the enrollment broker's website and computer

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system and mailings by the enrollment broker to the CCN's members regarding their choice period after the termination effective date and Enrollment Broker costs by the state to reenroll members to another CCN or fee for service;

14.3.4.13 Complete the performance of such part of the Provider Agreement which shall have not been terminated under the notice of termination;

14.3.4.14 Take such action as may be necessary, or as DHH may direct, for the protection of property related to this Provider Agreement which is in possession of the CCN in which DHH has or may acquire an interest;

14.3.4.15 In the event the Provider Agreement is terminated by DHH, continue to serve or arrange for provision of services to the members of the CCN until the effective date of termination. During this transition period, DHH shall continue to pay the applicable PMPM payments. Members shall be given written notice of the State's intent to terminate the Provider Agreement and shall be allowed to disenroll immediately without cause;

14.3.4.16 Provide all necessary assistance to DHH in transitioning members out of the CCN to the extent specified in the notice of termination. Such assistance shall include, but not be limited to, the forwarding of all medical or financial records related to the CCN's activities undertaken pursuant to this Provider Agreement; facilitation and scheduling of medically necessary appointments for care and services; and identification of chronically ill, high risk, hospitalized, and pregnant members in their last four (4) weeks of pregnancy.

The transitioning of records, whether medical or financial, related to the CCN's activities undertaken pursuant to this Provider Agreement shall be in a format approved by DHH or any party acting on behalf of DHH and shall be provided at no expense to DHH or another CCN acting on behalf of DHH; and

14.3.4.17 Promptly supply all information necessary to DHH or its designee for reimbursement of any outstanding financial obligations at the time of termination;

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Once DHH receives the notice of termination, DHH shall:

- a. Stop auto-assignment of members to the terminating plan as of the date written notification of termination is received by DHH;
- b. Review, revise and approve the CCN's termination plan and final report in accordance with the procedures outlined above;
- c. Review, revise and approve all correspondence to the CCN's members and providers prior to distribution; and
- d. Cease all new member enrollments in the CCN at such time as determined by DHH. This decision shall be at the sole discretion of DHH.

Any of the above-stated requirements may be waived or altered upon written request by the CCN and written approval by DHH.

14.4. Effect of Termination on Business Associate's HIPAA Privacy Requirements

14.4.1 Except as provided in §14.4.2 below, upon termination of this Provider Agreement, for any reason, any Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of contractors or agents of Business Associate. Business Associate shall not retain any copies of the Protected Health Information.

14.4.2 In the event that Business Associate determines that returning or destroying the Protected Health Information is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Upon a mutual determination that return or destruction of Protected Health Information is not feasible, Business Associate shall extend the protections of this Provider Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction not feasible, for so long as Business Associate maintains such Protected Health Information.

14.5 Use of Data

DHH shall have unlimited rights to use, disclose, or duplicate, for any purpose, all information and data developed, derived, documented, or furnished by the CCN resulting from this Provider Agreement.

14.6 Non-Waiver of Breach

The failure of DHH at any time to require performance by the CCN of any provision of this Provider Agreement, or the continued payment of the CCN by DHH, shall in no way affect the right of DHH to enforce any provision of this Provider Agreement; nor shall the waiver of any breach of any provision thereof be taken or held to be a waiver of any succeeding breach of such provision or as a waiver of the provision itself. No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Provider Agreement shall be waived except by the written agreement of the parties and approval of CMS, if applicable.

Waiver of any breach of any term or condition in this Provider Agreement shall not be deemed a waiver of any prior or subsequent breach. No term or condition of this Provider Agreement shall be held to be waived, modified, or deleted except by an instrument, in writing, signed by the parties hereto.

14.7 Non-Assignability

No assignment or transfer of this Provider Agreement or of any rights hereunder by the CCN shall be valid without the prior written consent of DHH.

14.8 Legal Services

No attorney-at-law shall be engaged through use of any direct funds provided by DHH pursuant to the terms of this Provider Agreement. Further, with the exception of attorney's fees specifically authorized by state or federal law, DHH shall under no circumstances become obligated to pay an attorney's fee or the costs of legal action to the CCN. This covenant and condition shall apply to any and all suits, legal actions, and judicial appeals of whatever kind or nature to which the CCN is a party.

14.9 Venue of Actions

Any suit, action or dispute arising out of this Provider Agreement shall be interpreted under applicable Louisiana laws, except for Louisiana's conflict of laws provision, in Louisiana administrative tribunals or district courts as appropriate.

14.10 Attorney's Fees

In the event that DHH shall bring suit or action to compel performance of or to recover monetary penalties for any breach of any stipulation, covenant, or condition of this Provider Agreement, the CCN shall and will pay to DHH such attorney's fees as the court may adjudge reasonable in addition to the amount of judgment and costs.

14.11 Independent Provider

It is expressly agreed that the CCN and any contractors and agents, officers, and employees of the CCN or any contractors in the performance of this Provider Agreement shall act in an independent capacity and not as officers, agents, express or implied, and/or employees of DHH or the State of Louisiana. It is further expressly agreed that this Provider Agreement shall not be construed as a partnership or joint venture between the CCN or any contractor and DHH and the State of Louisiana.

14.12 Governing Law and Place of Suit

It is mutually understood and agreed that this Provider Agreement shall be governed by the laws of the State of Louisiana except its conflict of laws provision both as to interpretation and performance. Any action at law, suit in equity, or judicial proceeding for the enforcement of this Provider Agreement or any provision thereof shall be instituted only in the courts of the State of Louisiana. Specifically any state court suit shall be filed in the 19th Judicial District as the exclusive venue for same, and any federal suit shall be filed in the Middle District for the State of Louisiana as the exclusive venue for same. This section shall not be construed as providing a right / cause of action to the CCN in any of the aforementioned Courts

14.13 Severability

If any provision of this Provider Agreement (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both DHH and CCN shall be relieved of all obligations arising under such provision. If the remainder of this Provider Agreement is capable of performance, it shall not be affected by such declaration or finding and shall be fully performed. In addition, if the laws or regulations governing this Provider Agreement should be amended or judicially interpreted as to render the fulfillment of the Provider Agreement impossible or economically infeasible, both DHH and the CCN will be discharged from further obligations created under the terms of the Provider Agreement.

14.14 Copyrights

If any copyrightable material is developed in the course of or under this Provider Agreement, DHH shall have a royalty free, non-exclusive, and irrevocable right to reproduce, publish, or otherwise use the work for DHH purposes.

14.15 Subsequent Conditions

The CCN shall comply with all requirements of this Provider Agreement and DHH shall have no obligation to enroll any CCN Program Members into the CCN until such time as all of said requirements have been met.

14.16 Incorporation of Schedules/Appendices

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

14.17 Titles

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

14.18 Safeguarding Information

The CCN shall establish written safeguards which restrict the use and disclosure of information concerning members or potential members to purposes directly connected with the performance of this Provider Agreement. The CCN's written safeguards shall:

- 14.18.1** Be comparable to those imposed upon the DHH by 42 CFR Part 431, Subpart F (2005, as amended) and La R.S. 45:56;
- 14.18.2** State that the CCN will identify and comply with any stricter state or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;
- 14.18.3** Require a written authorization from the member or potential member before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 CFR §164.508;
- 14.18.4** Not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and
- 14.18.5** Specify appropriate personnel actions to sanction violators.

14.19 Release of Records

The CCN shall release medical records of members as may be authorized by the member, as may be directed by authorized personnel of DHH, appropriate agencies of the State of Louisiana, or the United States Government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in this Provider Agreement. The ownership and procedure for release of medical records shall be controlled by the Louisiana revised statutes, including but not limited to, La.R.S. 40:1299.96, La.R.S. 13:3734, and La.C.Ev. Art. 510; and the 45 CFR Parts 160 and 164(HIPAA Privacy Rule).

14.20 Fraudulent Activity

The CCN shall report to DHH any cases of suspected Medicaid fraud or abuse by its members, network providers, employees, or contractors. The CCN shall report such suspected fraud or abuse in writing as soon as practical after discovering suspected incidents. The CCN shall report the following fraud and abuse information to DHH:

- a. The number of complaints of fraud and abuse made to the CCN that warrant preliminary investigation; and
- b. For each case of suspected provider fraud and abuse that warrants a full investigation:
 - 1) the provider's name and number,
 - 2) the source of the complaint,
 - 3) the type of provider,
 - 4) the nature of the complaint,
 - 5) the approximate range of dollars involved, and
 - 6) the legal and administrative disposition of the case.

The CCN shall adhere to the policy and process contained in the *CCN-P Policy and Procedure Guide* for referral of cases and coordination with the DHH's Program Integrity Unit for fraud and abuse complaints regarding members and providers.

14.21 Integration

This Provider Agreement shall be construed to be the complete integration of all understandings between the parties hereto. The CCN also agrees to be bound by the *CCN-P Policy and Procedure Guide* and any rules or regulations that may be promulgated. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or affect whatsoever unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other

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amendment hereto shall have any force or effect unless embodied in a written amendment executed and approved by the parties.

14.22 Hold Harmless

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

- 14.22.1** Any claims for damages or losses arising from services rendered by any contractor, person, or firm performing or supplying services, materials, or supplies for the CCN in connection with the performance of this Provider Agreement;
- 14.22.2** Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or federal Medicaid regulations or legal statutes, by CCN, its agents, officers, employees, or contractors in the performance of this Provider Agreement;
- 14.22.3** Any claims for damages or losses resulting to any person or firm injured or damaged by CCN, its agents, officers, employees, or contractors by CCN's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Provider Agreement in a manner not authorized by the Provider Agreement or by Federal or State regulations or statutes;"
- 14.22.4** Any failure of the CCN, its agents, officers, employees, or contractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;
- 14.22.5** Any claims for damages, losses, or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of DHH in connection with the defense of claims for such injuries, losses, claims, or damages specified above;
- 14.22.6** Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHH or their agents, officers or employees, through the intentional conduct, negligence or omission of the CCN, its agents, officers, employees or contractors.

In the event that, due to circumstances not reasonably within the control of CCN or DHH, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither the CCN, DHH, or contractor(s), will have any liability or

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obligation on account of reasonable delay in the provision or the arrangement of covered services; provided, however, that so long as this Provider Agreement remains in full force and effect, the CCN shall be liable for the core benefits and services required to be provided or arranged for in accordance with this Provider Agreement.

DHH will provide prompt notice of any claim against it that is subject to indemnification by CCN under this Provider Agreement. CCN may, at its sole option, assume the defense of any such claim. DHH may not settle any claim subject to indemnification hereunder without the advance written consent of CCN, which shall not be unreasonably withheld.

14.23 Hold Harmless as to the CCN Members

As a condition of participation in the Medicaid program, the CCN hereby agrees not to bill, charge, collect a deposit from, seek cost sharing or other forms of compensation, remuneration or reimbursement from, or have recourse against, CCN members, or persons acting on their behalf, for health care services which are rendered to such members by the CCN and its contractors, and which are core benefits and services under the members evidence of coverage.

The CCN further agrees that the CCN member shall not be held liable for payment for core benefits and services furnished under a contract, referral, or other arrangement, to the extent that those payments would be in excess of the amount that the member would owe if the CCN provided the service directly. The CCN agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by CCN and insolvency of CCN.

The CCN further agrees that this provision shall be construed to be for the benefit of CCN members of CCN, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the CCN and such members, or persons acting on their behalf.

14.24 Non-Discrimination

In accordance with 42 CFR 438.6 (d) (3) and (4), the CCN shall not discriminate in the enrollment of Medicaid individuals into the CCN. The CCN agrees that no person, on the grounds of handicap, age, race, color, religion, sex, national origin, or basis of health status or need for health care services shall be excluded from participation in, or be denied benefits of the CCN's program or be otherwise subjected to discrimination in the performance of this Provider Agreement or in the employment practices of the CCN. The CCN shall post in conspicuous

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places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all contracts.

14.25 Confidentiality of Information

The CCN shall assure that all material and information, in particular information relating to members or potential members, which is provided to or obtained by or through the CCN's performance under this Provider Agreement, whether verbal, written, electronic file, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws. The CCN shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Provider Agreement.

All information as to personal facts and circumstances concerning members or potential members obtained by the CCN shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of DHH or the member/potential member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of this Provider Agreement.

14.26 Employment of Personnel

In all hiring or employment made possible by or resulting from this Provider Agreement, the CCN agrees that:

- (1) There shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, or national origin; and
- (2) Affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all state and federal laws applicable to employment of personnel.

This requirement shall apply to, but not be limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff, termination, rates of pay or other forms of compensation, and selection for training including apprenticeship. The CCN further agrees to give public notice in conspicuous places available to employees and applicants for employment setting forth the provisions of this section. All solicitations or

advertisements for employees shall state that all qualified applicants will receive consideration for employment without regard to handicap, age, race, color, religion, sex, or national origin. All inquiries made to the CCN concerning employment shall be answered without regard to handicap, age, race, color, religion, sex, or national origin. All responses to inquiries made to the CCN concerning employment made possible as a result of this Provider Agreement shall conform to federal, state, and local regulations.

14.27 Political Activity

None of the funds, materials, property, or services provided directly or indirectly under this Provider Agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the "Hatch Act".

14.28 Force Majeure

The CCN and DHH may be excused from performance under this Provider Agreement for any period they may be prevented from performance by an Act of God; strike, war, civil disturbance or court order. The CCN shall, however, be responsible for the development and implementation of an Emergency Management Plan as specified in §14.38 of this Provider Agreement.

14.29 Conflict of Interest

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

The CCN shall comply with requirements for physician incentive plans, as required by 42 CFR 438.6(h) and set forth (for Medicare) in 42 CFR 422.208 and 422.210.

“(a) Assurances to CMS. Each organization will provide assurance satisfactory to the Secretary that the requirements of Sec. 422.208 are met.

(b) Disclosure to Medicare Beneficiaries. Each MA organization must provide the following information to any Medicare beneficiary who requests it:

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- (1) Whether the MA organization uses a physician incentive plan that affects the use of referral services.
- (2) The type of incentive arrangement.
- (3) Whether stop-loss protection is provided. The CCN represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The CCN further covenants that, in the performance of the Provider Agreement, no person having any such known interests shall be employed. “

14.30 Safety Precautions

DHH and HHS assume no responsibility with respect to accidents, illnesses or claims arising out of any activity performed under this Provider Agreement. The CCN shall take necessary steps to ensure or protect its members, itself, and its personnel. The CCN agrees to comply with all applicable local, state, and federal occupational and safety acts, rules, and regulations.

14.31 Loss of Federal Financial Participation (FFP)

The CCN hereby agrees to be liable for any loss of FFP suffered by DHH due to the CCN's, or its contractors', failure to perform the services as required under this Provider Agreement. Payments provided for under this Provider Agreement will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR §438.730.

14.32 HIPAA Compliance

The CCN shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (the HITECH act) and the rules and regulations promulgated there under (45 CFR Parts 160, 162, and 164). The CCN shall ensure compliance with all HIPAA requirements across all systems and services related to this Provider Agreement, including transaction, common identifier, and privacy and security standards, by the effective date of those rules and regulations.

14.33 Employee Education about False Claims Recovery

If the CCN receives annual Medicaid payments of at least \$5,000,000, the CCN must comply with Section 6032 of the Deficit Reduction Act (DRA) of 2005.

14.34 HIPAA Business Associate

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

14.35 Software Reporting Requirement

All reports submitted to DHH by the CCN must be in format accessible and modifiable by the standard Microsoft Office Suite of products or in a format accepted and approved by DHH.

14.36 National Provider Identifier

The HIPAA Standard Unique Health Identifier regulations (45 CFR §162 Subparts A & D) require that all covered entities (health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES).

Pursuant to the HIPAA Standard Unique Health Identifier regulations (45 CFR §162 Subparts A & D), and if the provider is a covered health care provider as defined in 45 CFR §162.402, the provider agrees to disclose its National Provider Identifier (NPI) to DHH once obtained from the NPPES. Provider also agrees to use the NPI it obtained from the NPPES to identify itself on all standard transactions that it conducts with DHH.

14.37 Debarment/Suspension/Exclusion

The CCN agrees to comply with all applicable provisions of 42 CFR Part 376 (2009, as amended), pertaining to debarment and/or suspension. As a condition of enrollment, the CCN should screen all employees and contractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or all federal health care programs. To help make this determination, the CCN may search the following websites: Office of Inspector General (OIG) List of Excluded Individuals/Entities) LEIE <http://www.oig.hhs.gov/fraud/exclusions.asp> ; the

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Health Integrity and Protection Data Bank (HIPDB) <http://www.npdb-hipdb.hrsa.gov/index.html> and/or the Excluded Parties List Serve (EPLS) <http://www.epls.gov>.

The CCN shall conduct a search of the website monthly to capture exclusions and reinstatements that have occurred since the last search and any exclusion information discovered should be immediately reported to DHH. Any individual or entity that employs or contracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR §1003.102(a)(2).

14.38 Emergency Management Plan

The CCN shall submit an emergency management plan as specified in the CCN Enrollment Process (*See CCN-P Policy and Procedure Guide*) for DHH approval. The emergency management plan shall specify actions the CCN shall conduct to ensure the ongoing provision of health services in an epidemic, disaster or manmade emergency including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies. Revisions to the DHH approved emergency plan shall be submitted to DHH for approval no less than 30 days prior to implementation of requested changes. The CCN shall submit an annual certification (from the date of the most recently approved plan) to DHH certifying that the emergency plan is unchanged from the previously approved plan.

14.39 Misuse of Symbols, Emblems, or Names in Reference to Medicaid

No person or CCN may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast, or other production, alone or with other words, letters, symbols or emblems the words "Medicaid," or "Department of Health and Hospitals" or "Bureau of Health Services Financing"," unless prior written approval is obtained from DHH. Specific written authorization from DHH is required to reproduce, reprint, or distribute any DHH form, application, or publication for a fee. State and local governments are exempt from this prohibition. A disclaimer that accompanies the inappropriate use of program or

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DHH terms does not provide a defense. Each piece of mail or information constitutes a violation.

14.40 Offer of Gratuities

By signing this agreement, the CCN signifies that no member of, or a delegate of, Congress, nor any elected or appointed official or employee of the State of Louisiana, the Government Accountability Office, DHHS, CMS, or any other federal agency has or shall benefit financially or materially from this Provider Agreement. This Provider Agreement may be terminated by DHH if it is determined that gratuities of any kind were offered to, or received by, any officials or employees from the state, its agents, or employees.

14.41 Interest

Interest generated through investments made by the CCN under this Provider Agreement shall be the property of the CCN and shall be used at the CCN's discretion.

14.42 Interpretation Dispute Resolution Procedure

The CCN may request in writing an interpretation of the issues relating to the Provider Agreement from the Medicaid Deputy Director over the Medicaid Coordinated Care Section. In the event the CCN disputes the interpretation by Medicaid Deputy Director, the CCN shall submit a written reconsideration request to the Medicaid Director.

The CCN shall submit, within-twenty-one (21) days of said interpretation, a written request disputing the interpretation directly to the Medicaid Director. The ability to dispute an interpretation does not apply to language in the Provider Agreement that is based on federal or state statute, regulation or case law.

The Medicaid Director shall reduce the decision to writing and serve a copy to the CCN. The written decision of the Medicaid Director shall be final. The Medicaid Director will render the final decision based upon the written submission of the CCN and the Medicaid Deputy Director, unless, at the sole discretion of the Medicaid Director, the Medicaid Director allows an oral presentation by the CCN and the Medicaid Deputy Director or his/her designee. If such a presentation is allowed, the information presented will be considered in rendering the decision.

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Pending final determination of any dispute over a DHH decision, the CCN shall proceed diligently with the performance of the Provider Agreement and in accordance with the direction of DHH.

14.43 Rate Adjustment

The CCN and DHH both agree that the PMPM rates identified in this Provider Agreement shall be in effect during the period identified on the CCN Rate Schedule that will be posted on DHH's website. Rates will be risk adjusted during the Provider Agreement period based on DHH and actuarial analysis, and subject to CMS review and approval.

The CCN and DHH both agree that the adjustments to the PMPM rate(s) required pursuant to this section shall occur only by written change to the *CCN-P Policy and Procedure Guide* and should either the CCN or DHH refuse to accept the revised PMPM rate, the provisions of **§13.3.4** of this Provider Agreement shall apply.

14.44 Payment of Providers

Payment of both contracted and non-participating providers shall, at a minimum, follow the same standards as those contained in 42 CFR §447.45 (d)(1)-(3), (5) and (6) as determined by DHH. This includes the following: Providers must submit all claims no later than 12 months from the date of service. The CCN shall pay 90% of all clean claims from each Medicaid provider type category, within thirty (30) days of the date of receipt. The CCN shall pay 99% of all clean claims each Medicaid provider type categories, within ninety (90) days of the date of receipt. These provisions shall also apply to payments to hospitals and other network providers. The date of receipt is the date the CCN receives the claim, as indicated by its data stamp on the claim. The date of payment is the date of the check or other form of payment. The CCN and its providers may, by mutual agreement, establish an alternative payment schedule.

14.45 Prohibited Payments

Payment for the following shall not be made:

14.45.1 Organ transplants, **unless** the State plan has written standards meeting coverage guidelines specified;

14.45.2 Non-emergency services provided by or under the direction of an excluded individual;

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- 14.45.3 Any amount expended for which funds may not used under the Assisted Suicide Funding Restriction Act of 1997;
- 14.45.4 Any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan; and
- 14.45.5 Any amount expended for home health care services unless the organization provides the appropriate surety bond.

14.46 Order of Precedence

In the event of any inconsistency or conflict among the document elements of this Agreement, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

1. Standard Clauses of PE-50 Enrollment Forms;
2. The body of this Agreement;
3. The appendices attached to the body of this Agreement
4. *CCN-P Policy and Procedure Guide*
5. *CCN-P Systems Companion Guide*
6. *Quality Companion Guide*
7. The CCN's approved:
 - a. Marketing Plan on file with DHH
 - b. Action and Grievance System Procedures on file with DHH
 - c. Quality Assurance Plan on file with DHH
 - d. ADA Compliance Plan on file with DHH
 - e. Fraud and Abuse Prevention Plan on file with DHH

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IN WITNESS WHEREOF the CCN, by its authorized agent, submits and agrees to comply with the all the terms and conditions set forth in this Provider Agreement as of the first day of _____ of _____, 2010 and requirements set forth in the CCN Enrollment Process in the *CCN-P Policy and Procedure Guide*.

(Coordinated Care Network)

BY: _____

Print Name: _____

Title: _____

Witness:

Witness:

IN WITNESS WHEREOF the DHH, by its authorized agent, has received this Provider Agreement as of the first day of _____ of _____, 2010. Final approval of this Provider Agreement will be dependent upon the CCN passing all elements in the CCN Enrollment Process and determined "certified" to proceed as a Coordinated Care Network-Prepaid provider.

BY: _____

Print Name: _____

Title: _____

Witness:

Witness:

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IN WITNESS WHEREOF the DHH, by its authorized agent, approves this Provider Agreement as of the first day of _____ of _____, 2010 and determines the CCN to be certified and eligible to be enrolled in the Medicaid Program. Final approval of this Provider Agreement is contingent upon approval by the Center of Medicaid/Medicare Services (CMS).

BY: _____

Print Name: _____

Title: _____

Witness:

Witness:

APPENDIX A: DEFINITIONS OF TERMS

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DEFINITIONS

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

AAFP - American Academy of Family Physicians

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

Action - The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service, the failure to provide services in a timely manner (as defined by DHH), and the failure of the CCN to act within the timeframes for the resolution of grievances and appeals as described in 42 CFR §438.400(b); and in a rural area with only one CCN, the denial of a member's right to obtain services outside the provider network, as described in §438.52(b)(2)(ii).

Actuarially Sound PMPM rates - PMPM rates that (1) have been developed in accordance with generally accepted actuarial principles and practices; (2) are appropriate for the populations to be covered, and the services to be furnished under the contract; and (3) have been certified, as meeting the requirements of this definition, by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board

Adequate Network/Adequacy of Network - Refers to the network of health care providers for a CCN (whether in- or out-of-network) that is sufficient in numbers and types of providers and facilities to ensure that all services are accessible to members without unreasonable delay. Adequacy is determined by a number of factors, including but not limited to, provider-patient ratios for primary care providers; geographic accessibility and travel distance; waiting times for appointments and hours of provider operations.

Adjustments to Smooth Data - Adjustments made, by cost-neutral methods, across rate cells, to compensate for distortions in costs, utilization, or the number of eligibles.

Advance Directive - A written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

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

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

Age Discrimination Act of 1975 - prohibits discrimination on the basis of age in programs and activities receiving federal financial assistance. The Act, which applies to all ages, permits the use of certain age distinctions and factors other than age that meet the Act's requirements. The Age Discrimination Act is enforced by the Civil Rights Center.

Aged/Blind/Disabled A unique eligibility category within the Medicaid Program that defines specific conditions for which a person may be determined eligible to receive Medicaid health care services. Applies individuals who are eligible for Medicaid due to age, blindness or disability.

Agent - Any person or entity with delegated authority to obligate or act on behalf of another party.

Ambulatory Care - Preventive, diagnostic and treatment services provided on an outpatient basis.

Americans with Disabilities Act of 1990 (ADA) - The Americans with Disabilities act prohibits discrimination against people with disabilities in employment, transportation, public accommodation, communications and governmental activities. The ADA also establishes requirements for telecommunications relay services.

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

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

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

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Behavioral Health Services (BHS) - Mental health and substance abuse services, which are provided to enrollees with emotional, psychological, substance abuse, psychiatric symptoms and/or disorders. Basic behavioral health services are provided in the enrollee's PCP office by the enrollee's PCP as part of primary care service activities as well as those services provided in an FQHC. Specialized mental health services shall include, but not be limited to, services specifically defined in state plan and provided by a psychiatrist, psychologist, and/or mental health rehabilitation provider to those enrollees with a primary diagnosis of a behavioral disorder.

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

Bureau of Health Services Financing (BHSE) - The agency within the Louisiana Department of Health & Hospitals, Office of Management & Finance that has been designated as Louisiana's single state Medicaid agency to administer the Medicaid and CHIP programs.

Business Day - Traditional workdays, including Monday, Tuesday, Wednesday, Thursday and Friday. State holidays are excluded and traditional work hours of 8:00 a.m. - 5:00 p.m.

CAHPS - The Consumer Assessment of Healthcare Providers and Systems is a standardized survey of members' experiences with ambulatory and facility-level care established by the Agency for Healthcare Research and Quality (AHRQ).

Calendar Days - All seven (7) days of the week. Unless otherwise specified, the term "days" in this *Guide* refers to calendar days.

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

Care Management - Overall system of medical management encompassing Utilization Management, Referral, Case Management, Care Coordination, Continuity of Care and Transition Care, Chronic Care Management, Quality Care Management, and Independent Review.

Case Management - Refers to a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a member's needs through communication and available resources to promote high quality, cost-effective outcomes. Case management

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services are defined as services provided by qualified staff to a targeted population to assist them in gaining timely access to the full range of needed services including medical, social, educational, and other support services. Case Management services include an individual needs assessment and diagnostic assessment, individual treatment plan development, establishment of treatment objectives, and monitoring outcomes.

Cause – Specified reasons that allow mandatorily enrolled CCN members to change their CCN choice. Term may also be referred to as “good cause.”

CCN-P Policy and Procedure Guide - The policy and procedure *Guide* for Prepaid Coordinated Care Networks and their providers.

CCN-P Systems Companion Guide - A supplement to the Policy and Procedure Guide that outlines the formatting and reporting requirements concerning encounter data, interfaces between the FI and the CCN and enrollment broker and the CCN.

Centers for Disease Control/Advisory Committee on Immunization Practices (CDC/ACIP) Federal agency and committee whose role is to provide advice that will lead to a reduction in the incidence of vaccine-preventable diseases in the United States and an increase in the safe use of vaccines and related biological products.

Centers for Medicare and Medicaid Services (CMS) - The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children’s Health Insurance Program under Title XXI of the Social Security Act. Formerly known as Health Care Financing Administration (HCFA)

Certified Nurse Midwife (CNM) - An advanced practice registered nurse educated in the disciplines of nursing and midwifery and certified according to a nationally recognized certifying body, such as the American College of Nurse Midwives Certification Council, as approved by the state board of nursing and who is authorized to manage the nurse midwifery care of newborns and women in the ante-partum, intra-partum, postpartum, and/or gynecological periods.

CFR - Code of Federal Regulations.

CHIP - **Children’s Health Insurance Program** created in 1997 by Title XXI of the Social Security Act. Known in Louisiana as CHIP

Chisholm Class Members - All current and future recipients of Medicaid in the state of Louisiana under age twenty-one who are now on or will in the future be placed on the Developmental Disabilities Request for Services Registry.

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

Chronic Care Management Program (CCMP) - A system of coordinated health care in which interventions and communications for populations with conditions in which patient self-care efforts are significant. Chronic care management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

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

Claim - A request for payment for benefits received or services rendered.

Clean Claim - Claim means 1) a bill for services 2) a line item of service or 3) all services for one recipient within a bill. Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

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

Cold Call Marketing - Any unsolicited personal contact with a Medicaid eligible individual by the CCN, its staff, its volunteers or its vendors/contractors with the purpose of influencing the Medicaid eligible individual to enroll in the CCN or either to not enroll in or disenroll from another CCN.

CommunityCARE - Refers to the Louisiana Medicaid Primary Care Case Management (PCCM) program which links Medicaid/CHIP eligibles to a primary care provider as their medical home. .

Community Mental Health Clinic (CMHC) - Facilities providing outpatient behavioral health services throughout the Office of Behavioral Health's geographic regions and service districts. Services include: screening and assessment; emergency crisis care; individual evaluation and treatment; medication administration and management; clinical casework services; specialized services for children and adolescents; specialized services related to for criminal justice; specialized services for the elderly; and pharmacy services.

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Co-payment - Any cost sharing payment for which the Medicaid/CHIP CCN member is responsible, in accordance with 42 CFR, § 447.50 and Section 5006 of the American Recovery and Reinvestment Act (ARRA) for Native American members.

Coordinated Care Network (CCN) - An entity designed to improve performance and health outcomes through the creation of cost effective integrated healthcare delivery system that provides a continuum of evidence-based, quality-driven healthcare services for Medicaid/CHIP eligibles.

Coordinated Care Network - Prepaid (CCN-P) - A prepaid entity that participates in the Louisiana Medicaid Program, referred to in the Provider Agreement as a Coordinated Care Network- Prepaid. The entity is regulated by the Louisiana Department of Insurance with respect to licensure and financial solvency, pursuant to Title 22 of the Louisiana Revised Statutes, but shall, solely with respect to its products and services offered pursuant to the Louisiana Medicaid Program be regulated by the Louisiana Department of Health and Hospitals.

Coordinated Care Network - Shared Savings (CCN-S) - An entity that provides enhanced primary care case management services that include primary care provider (PCPs) primary care management services. The CCN-S expands the roles and responsibilities of the primary care providers through the establishment of patient-centered medical homes; and creation of a formal and distinct network of primary care providers to coordinate the full continuum of care while achieving budget and performance goals and benchmarks.

Coordinated Care Program - The program within the Louisiana Medicaid Program providing statewide leadership to most effectively utilize resources to promote the health and well being of Louisianans in DHH's CommunityCARE, Shared Savings Coordinated Care Network and Prepaid Coordinated Care Network programs.

Coordination of Benefits (COB) - Refers to the activities involved in determining Medicaid benefits when a recipient has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.

Contract - An agreement between a CCN and a provider of services to furnish core benefits and services to members, or with a marketing organization, or with any other organization or person who agrees to perform any administrative function or service for the CCN specifically related to fulfilling the CCN's obligations under the terms of this agreement.

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

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Contractor - A person, agency or organization with which a CCN has contracted or delegated some of its management functions or other contractual responsibilities to provide covered services to its members.

Convicted - A judgment of conviction entered by a federal, state or local court, regardless of whether an appeal from that judgment is pending.

Core Benefits and Services - A schedule of health care benefits and services required to be provided by the CCN to Medicaid/CHIP CCN members as specified under the terms and conditions of this Provider Agreement and Louisiana Medicaid State Plan.

Corrective Action Plan (CAP) - A plan developed by the Coordinated Care Network that is designed to ameliorate an identified deficiency and prevent reoccurrence of that deficiency. The CAP outlines all steps/actions and timeframe necessary to address and resolve the deficiency.

Cost-Based Reimbursement - A method of payment of medical care by third parties for services delivered to patients. The amount of payment is based on the allowable costs to the provider for delivering the service.

Cost Neutral - The mechanism used to smooth data, share risk, or adjust for risk that will recognize both higher and lower expected costs and is not intended to create a net aggregate gain or loss across all payments.

Covered Services - Those health care services/benefits to which an individual eligible for Medicaid/CHIP is entitled under the Louisiana Medicaid State Plan.

CPT® - Current Procedural Terminology, current version, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. DHHS designated the CPT code set as the national coding standard for physician and other health care professional services and procedures under HIPAA.

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

Department (DHH) - The Louisiana Department of Health and Hospitals, referred to as DHH throughout this Provider Agreement.

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

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includes more than 300 programs, covering a wide spectrum of activities, including medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; overseeing Medicare, Medicaid and CHIP; and providing financial assistance for low-income families.

Disease Management (DM) - see Chronic Care Management

Disenrollment - Action taken by DHH or its designee to remove a Medicaid/CHIP CCN member from the CCN following the receipt and approval of a written request for disenrollment or a determination made by DHH or its designee that the member is no longer eligible for Medicaid/CHIP or the CCN Program

Duplicate Claim - A claim that is either a total or partial duplicate of services previously paid.

Durable Medical Equipment, Prosthetics, Orthotics and certain Supplies (DMEPOS) - DME is inclusive of equipment which 1) can withstand repeated use, 2) is primarily and customarily used to serve a medical purpose; 3) generally is not useful to a person in the absence of illness or injury, and 4) is appropriate for use in the home. POS is inclusive of prosthetics, orthotics and certain supplies. Certain supplies are those medical supplies that are expendable nature, such as catheters and diapers.

Direct Marketing/Cold Call - Any unsolicited personal contact with or solicitation of a Medicaid/CHIP eligible in person, through direct mail advertising or telemarketing by an employee or agent of the CCN for the purpose of influencing an individual to enroll with the CCN.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) - A federally required Medicaid benefit for individuals under the age of 21 years that expands coverage for children and adolescents beyond adult limits to ensure availability of 1) screening and diagnostic services to determine physical or mental defects and 2) health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (CFR 440.40 (b)). EPSDT requirements help to ensure access to all medically necessary health services within the federal definition of "medical assistance".

E-Consultation - The use of electronic computing and communication technologies in consultation processes.

Electronic Health Records (EHR) - A computer-based record containing health care information. This technology, when fully developed, meets provider needs for real-time data access and evaluation in medical care. Implementation of EMR increases the potential for more efficient care, speedier communication among providers and management of CCNs.

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

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Eligible - An individual determined eligible for assistance in accordance with the Medicaid State Plan(s) under the Title XIX or Title XXI of the Social Security Act.

Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part..

Emergency Services - Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 CFR 438.114(a) and 1932(b)(2) and that are needed to screen, evaluate, and stabilize an emergency medical condition. Services defined as such under Section 1867 (e) of the Social Security Act (“anti-dumping provisions”). If an emergency medical condition exists, the CCN is obligated to pay for the emergency service. Coverage of emergency services must not include any prior authorization requirements and the “prudent layperson” standard shall apply to both in-plan and out-of-plan coverage.

Encounter Data - Records of medically-related services rendered by a provider to a CCN member on a specified date of service. This data is inclusive of all services for which the CCN has any financial liability to a provider.

Encounter Data Adjustment - Adjustments to encounter data that are allowable under the Medicaid Management Information System (MMIS) for HCFA 1500, UB 92, KM-3 and NCPDP version 3.2 claim forms as specified in the *CCN-P Systems Companion Guide*.

Enrollee - Louisiana Medicaid or CHIP eligible (recipient) who is currently enrolled in a CCN.

Enrollment - -The process conducted by the Enrollment Broker by which an eligible Medicaid/CHIP recipient becomes a member of a CCN.

Enrollment Broker - The state’s contracted or designated agent that performs functions related to outreach, education, choice counseling, enrollment and disenrollment of potential enrollees and enrollees into a CCN.

Evidence-Based Practice - Clinical interventions that have demonstrated positive outcomes in several research studies to assist consumers in achieving their desired goals of health and wellness.

Excluded Populations - Medicaid/CHIP eligibles that are excluded from enrollment in a CCN and may not voluntarily enroll.

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External Quality Review Organization (EQRO) – an organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs EQR and other related activities as set forth in federal regulations, or both.

Expanded Services - A covered service provided by the CCN which is currently a non-covered service(s) in the Medicaid State Plan or is an additional Medicaid covered service furnished by the CCN to Medicaid CCN members for which the CCN receives no additional capitated payment, and is offered to members in accordance with the standards and other requirements set forth in the Provider Agreement.

Experimental Procedure/Service - A procedure or service that requires additional research to determine safety, effectiveness, and benefit compared to standard practices and characteristics of patients most likely to benefit. The available clinical scientific data may be relatively weak or inconclusive. The term applies only to the determination of eligibility for coverage or payment.

Family Planning Services - Services that include examinations and assessments, diagnostic procedures, health education, and counseling services related to alternative birth control and prevention as prescribed and rendered by physicians, hospitals, clinics and pharmacies.

Federal Financial Participation (FFP) - Also known as federal Match, the percentage of federal matching dollars available to a state to provide Medicaid and CHIP services. The federal Medical Assistance Percentage (FMAP) is calculated annually based on a formula designed to provide a higher federal matching rate to States with lower per capita income.

Federally Qualified Health Center (FQHC) - An entity that receives a grant under Section 330 of the Public Health Service Act, as amended (Also see Section 1905(1)(2)(B) of the Social Security Act) to provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.

Fee for Service (FFS) - A method of provider reimbursement based on payments for specific services rendered to an enrollee.

FFS Provider - An institution, facility, agency, person, corporation, partnership, or association approved by DHH which accepts payment in full for providing benefits, the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.

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

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

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

Full-Time Equivalent Position (FTE) - Refers to the equivalent of one (1) individual full-time employee who works forty (40) hours per week; or a full-time primary care physician shall be defined as a physician delivering outpatient preventive and primary (routine, urgent and acute) care for thirty-two (32) hours or more per week (exclusive of travel time) for a minimum of four (4) days per week.

GEO Coding - Refers to the process in which implicit geographic data is converted into explicit or map-form images.

GEO Mapping - The process of finding associated geographic coordinates (often expressed as latitude and longitude) from other geographic data, such as street addresses, or zip codes (postal codes). With geographic coordinates the features can be mapped and entered into Geographic Information Systems, or the coordinates can be embedded into media.

Geographic Service Area - The designated geographical service area in which the CCN is authorized by the Provider Agreement to deliver core benefits and services to Medicaid/CHIP eligibles. The minimum geographic service area a CCN may provide core benefits shall be one parish. See Service Area.

Go-Live Date - The date the CCN shall begin providing services to Medicaid/CHIP members.

Good Cause - see "cause".

Grievance - An expression of member/provider dissatisfaction about any matter other than an action, as action is defined. Examples of grievances include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.

Health Care Financing Administration (HCFA) - Prior to 2001, the name for the federal agency within the Department of Health and Human Services that is responsible for the administration of the Medicaid and CHIP programs. In 2001 the name was changed to Centers for Medicare and Medicaid Services (CMS)

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Health Care Professional - A physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

Health Care Provider - a health care professional or entity who provides health care services or goods.

Healthcare Effectiveness Data and Information Set (HEDIS) - A set of performance measures developed by the National Committee for Quality Assurance (NCQA). The measures were designed to help health care purchasers understand the value of health care purchases and measure plan (e.g. CCN) performance.

HIPAA - Health Information Portability Administration Act

Home and Community Based Services Waiver (HCBS) - Under Section 1915 (c) of the Social Security Act States may request waivers of state wideness, comparability of services, and community income and resource rules for the medically needy in order to develop Medicaid-financed community-based treatment alternatives. Non-state plan services that may be offered include case management, homemaker/home health aide services, personal care services, adult day health, habilitation, and respite care. Current HCBS waivers in Louisiana are New Opportunities Waiver (NOW), Children's Choice, Elderly and Disabled Adult Waiver, Adult Day Health Care, Supports Waiver, Adult Residential Options.

Hospice - Services provided under fee-for-service as described in Louisiana Medicaid State Plan and 42 CFR §418, which are provided to terminally ill individuals, with a prognosis of 6 months or less, who elect to receive hospice services provided by a certified hospice agency.

ICD-9-CM codes -**International Classification of Diseases, 9th Revision, Clinical Modification** Codes currently used to identify diagnosis. CCNs shall move to ICD-10-CM as it becomes effective..

IEP Services - These are therapies included in the student's Individualized Education Plan (IEP). Included are physical therapy, occupational therapy, speech/language therapy, audiology and some psychological therapy. The enrolled provider must be a public school system and they certify the state match via CPE. The school board does bill fee-for-service through the MMIS claims payment system which acts as an interim payment. At the end of the year there is a cost settlement process.

Immediate - In an immediate manner; instant; instantly or without delay.

Implementation Date - The date the CCN's Provider Agreement has been approved to proceed to DHH's on-site Readiness Review process. It differs from the service start-up or "go live" date (which should be roughly five months from the implementation date). At implementation,

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a CCN can begin the process of establishing all systems for the subsequent enrollment of Medicaid/CHIP eligibles and service start-up date and preparing for the DHH's on-site Readiness Review. Enrollment of members will not begin until the CCN has passed the as specified in the CCN Enrollment Process or at the "go live" date.

Incentive Arrangement - Any payment mechanism under which a contractor may receive additional funds over and above the rate it was paid for meeting targets specified in the contract.

Incurred But Not Reported (IBNR) - Services rendered for which claim/encounter has not been received by the CCN.

Individual Practice - Independent physicians who work in their own private practices.

Information Systems (IS) - A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, *i.e.* structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.

Insolvency - A financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets, or as determined by the Louisiana Department of Insurance pursuant to Title 22 of the Louisiana Revised Statutes.

Institutionalized - A patient in a nursing facility; an in-patient in a medical institution or institution for mental disease, whereby payment is based on a level of care provided in a nursing facility; or receives home and community-based waiver services.

Investigational Procedure/Service - see Experimental Procedure/Service.

Kick Payment - The method of reimbursing prepaid CCNs in the form of a separate one (1) time fixed payment for specific services in addition to the PMPM payment.

KIDMED - Louisiana's screening component for Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) program provided for Medicaid/CHIP eligible children under the age of 21. Required by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89).

LaCHIP - Refers to the Louisiana's Medicaid expansion CHIP (Title XXI) Program that provides health coverage to uninsured children under age 19, whose families have a net income up to 200 percent of the Federal Poverty Level (FPL); and whose income exceeds the Medicaid limit. Phase 1 includes children ages 6-18 with income from 100% up to and including 133% FPL;

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Phase II includes children with income from 134% up to and including 150% FPL; Phase 3 includes children with income from 151% FPL up to and including 200% FPL.

LaCHIP Prenatal Program (Phase IV) - Louisiana's separate CHIP (Title XXI) program which provides prenatal coverage through the Medicaid delivery system from conception to birth for children whose uninsured mothers are ineligible for Medicaid and have net family income at or below 200%.

LaCHIP Affordable Plan (Phase V) - Louisiana's separate state CHIP (Title XXI) program that provides health coverage to uninsured children in families with income from 201% up to and including 250% FPL. The program is administered by the Louisiana Office of Group Benefits.

LaMOMS - Medicaid program for pregnant women with income up to and including 133% FPL and optional Medicaid program for pregnant women with income from 134% up to and including 185% FPL. With a 15% income disregard, the income limit is in effect, 200% FPL. The program provides pregnancy-related services, delivery and post-partum care for 60 days after the pregnancy ends for women whose sole basis of eligibility is pregnancy.

Louisiana Children's Health Insurance Program (LaCHIP) - Louisiana's name for the Children's Health Insurance Plan created by Title XXI of the Social Security Act in 1997. Provides health care coverage for uninsured children up to age 19 through a Medicaid expansion program for children at or below 200% FPL and a separate state CHIP program for the unborn prenatal option and for children with income from 200% up to and including 250% FPL.

Louisiana Department of Health and Hospitals (DHH) - The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Louisiana.

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

Mandatory Population/Enrollee - The groups of Medicaid/CHIP eligibles who are required to enroll in a Medicaid CCNs and whose participation is not voluntary.

Marketing means any communication, from an CCN to a Medicaid/CHIP enrollee who is not enrolled in that CCN, that can reasonably be interpreted as intended to influence the recipient to enroll in that particular CCN's Medicaid product, or either to not enroll in, or to disenroll from, another CCN's Medicaid product.

Marketing Materials - Information produced in any medium, by or on behalf of a CCN that can reasonably be interpreted as intended to market to potential enrollees or enrollees.

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Mass Media - A method of public advertising that can create CCN name recognition among a large number of Medicaid/CHIP recipients and can assist in educating them about potential health care choices. Examples of mass media are radio spots, television advertisements, newspaper advertisements, newsletters, and video in doctor's office waiting rooms.

Material Change - Material changes are changes affecting the delivery of care or services provided under this Provider Agreement. Material changes include, but are not limited to, changes in: composition of the provider network, contractor network, CCN's complaint and grievance procedures; health care delivery systems, services, changes to expanded services; benefits; geographic service area; enrollment of a new population; procedures for obtaining access to or approval for health care services; any and all policies and procedures that required DHH approval prior to implementation; and the CCN's capacity to meet minimum enrollment levels. DHH shall make the final determination as to whether a change is material.

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

Medicaid Eligibility Office - The Department of Health and Hospital's offices located within select parishes of the state and State Office that are responsible for initial and ongoing financial eligibility determination.

Medicaid/CHIP Eligible - Refers to an individual determined eligible, pursuant to federal and state law, to receive medical care, goods and services for which DHH may make payments under the Medicaid or CHIP Programs, who is enrolled in the Medicaid or CHIP Program, and on whose behalf payments may or may not have been made.

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

Medicaid/CHIP Recipient - An individual who has been determined eligible, pursuant to federal and state law, to receive medical care, goods or services for which DHH may make payments under the Medicaid or CHIP Program, who may or may not be currently enrolled in the Medicaid or CHIP Program, and on whose behalf payment is made.

Medicaid FFS Provider - An institution, facility, agency, person, corporation, partnership, or association that has signed a PE 50 agreement, been approved by DHH, and accepts payment in full for providing benefits, the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.

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Medical Home – Systems of care led by a team of primary care providers who partner with the patient, the patient’s family and the community to coordinate care in all settings, from specialists and hospitals to pharmacies, nursing homes and home health agencies. Primary care providers are inclusive of physician-led and nurse-practitioner-led primary care practices.

Medical Loss Ratio – The percentage of PMPM payments received from DHH that is used to pay medical claims from treating providers for members.

Medical Necessity Review Organization" or "MNRO" - means a health insurance issuer or other entity licensed or authorized pursuant to La RS 22:1122 to make medical necessity determinations for purposes other than the diagnosis and treatment of a medical condition.

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

Medical Vendor Administration (MVA) – Refers to the name for the budget unit specified in the Louisiana state budget which contains the administrative component of the Bureau of Health Services Financing (Louisiana’s single state Medicaid agency).

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

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Medicare - The federal medical assistance program in the United States authorized in 1965 by Title XVIII of the Social Security Act, to address the medical needs. Medicare is available to U.S. citizens 65 years of age and older and some people with disabilities under age 65.

Member Month - A month of coverage for a Medicaid/CHIP eligible who is enrolled in the CCN.

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

Monetary Penalties - Monetary sanctions that may be assessed whenever a CCN, its providers, and/or its contractors fail to achieve certain performance standards and other items defined in the terms and conditions of the provider agreement.

National Response Framework - Part of the Federal Emergency Management Agency (FEMA), The National Response Framework presents the guiding principles that enable all response partners to prepare for and provide a unified national response to disasters and emergencies. The framework establishes a comprehensive, national, all-hazards approach to domestic incident response.

National Committee for Quality Assurance (NCQA) - A not-for-profit organization that performs quality-oriented accreditation reviews on health maintenance organizations and similar types of managed care plans.

Network - As utilized in the Provider Agreement, “network” may be defined as a group of participating providers linked through contractual arrangements to a CCN to supply a range of primary and acute health care services. Also referred to as Provider Network.

Network Adequacy - Refers to the network of health care providers for a CCN (whether in- or out-of-network) that is sufficient in numbers and types of providers and facilities to ensure that all services are accessible to members without unreasonable delay. Adequacy is determined by a number of factors, including but not limited to, provider patient ratios; geographic accessibility and travel distance; waiting times for appointments and hours of provider operations.

Non-Contracting Provider - A person or entity that provides hospital or medical care but does not have a contract or contract with the CCN.

Newborn - A live infant born to a CCN member.

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Non-Covered Services - Services not covered under the Title XIX Louisiana State Medicaid Plan.

Non-Emergency - An encounter by a CCN member who has presentation of medical signs and symptoms, to a health care provider, and not requiring immediate medical attention.

Non-Participating Physician - A physician licensed to practice that has not contracted with or is not employed by the CCN to provide health care services.

Non-Urgent Sick Care - Medical care given for an acute onset of symptoms that is not emergent or urgent in nature. Examples of non-urgent sick visit include cold symptoms, sore throat, and nasal congestion; requires face-to-face medical attention within 48-72 hours of member notification of a non-urgent condition, as clinically indicated.

Nurse Practitioner (NP)- An advanced practice registered nurse educated in a specified area of care and certified according to the requirements of a nationally recognized accrediting agency such as the American Nurses Association's American Nurses Credentialing Center, National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties, or the National Certification Board of Pediatric Nurse Practitioners and Nurses, or as approved by the state board of nursing and who is authorized to provide primary, acute, or chronic care, as an advanced nurse practitioner acting within his/her scope of practice to individuals, families, and other groups in a variety of settings including, but not limited to, homes, institutions, offices, industry, schools, and other community agencies.

Open Enrollment - The period of time when a CCN member may change CCNs without cause (*once per year after initial enrollment*).

Out-of-Network Services - Medicaid services not included in the CCN's core benefits and reimbursed fee-for-service by the State.

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

Per Member Per Month (PMPM) - The amount of money paid or received on a monthly basis for each individual enrolled.

Performance Improvement Projects (PIP) - Projects to improve specific quality Performance Measures through ongoing measurements and interventions that result in significant improvement, sustained over time, with favorable effect on health outcomes and member satisfaction.

Performance Measures - Specific operationally defined performance indicators utilizing data to track performance and quality of care and to identify opportunities for improvement related important dimensions of care and service.

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Personal Health Record (PHR) - A health record that is initiated and maintained by an individual.

Physician Assistant - A health care professional who is a graduate of a program accredited by the Committee on Allied Health Education and Accreditation or its successors and who has successfully passed the national certificate examination administered by the National Commission on the Certification of Physicians' Assistants or its predecessors and who is approved and licensed by the Louisiana State Board of Medical Examiners to perform medical services under the supervision of a physician or group of physicians who are licensed and registered with the board to supervise such assistant. A physician assistant may perform certain duties such as history taking, diagnosis, drawing blood samples, urinalysis, and injections under the supervision of a physician.

Physician Extender - Nurse practitioners, certified nurse mid-wives, and physician assistants linked to a physician group who provide primary care services.

Physician Practice Connections®Patient-Center Medical Home (PPC-PCMH™) - NCQA recognition for physician practices that meet specific criteria for medical homes.

Plan of Care - Strategies designed to guide health care professionals involved with patient care. Such plans are patient specific and are meant to address the total status of the patient. Care plans are intended to ensure optimal outcomes for patients during the course of their care.

PMPM Rate - The per-member, per-month rate paid to the CCN for the provision of medical services to CCN members.

Policies - The general principles by which DHH is guided in its management of the Title XIX program, and as further defined by DHH promulgations and by state federal rules and regulations.

Post-Stabilization Care Services - Covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain, improve or resolve the member's condition pursuant to 42 CFR 422.113(c)(1), Social Security 1852(d)(2) and 42 CFR § 438.114(a).

Potential Enrollee - A Medicaid/CHIP eligible (recipient/ who is subject to mandatory enrollment or may voluntarily elect to enroll in a CCN, but is not yet an enrollee of a specific CCN.

Poverty Level - Poverty guidelines issued annually in late January or early February by the Department of Health & Human Services for the purpose of determining financial eligibility for certain programs including Medicaid and CHIP and which are based on household size.

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Guidelines are updated from the Census Bureau's latest published weighted average poverty thresholds.

Preconception/Interconception Care - Interventions that aim to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management, emphasizing those factors which must be acted on before conception or early in pregnancy to have maximal impact. Thus, it is more than a single visit and routine well-woman care. It includes care before a first pregnancy or between pregnancies (interconception). While the predominant component addresses woman's health it includes interventions directed at males, couples, families and society at large.

Prepaid Model - A method of paying a CCN for the cost of health care services in advance of their use. A method providing in advance for the cost of predetermined benefits for a population group, through regular periodic payments in the form of premiums, dues, or contributions.

Preventive Care - Refers to the treatment to avert disease/illness and/or its consequences. The term is used to designate prevention and early detection programs rather than restorative or treatment programs. There are three levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred; requires a face-to-face visit within 4 weeks of member request

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

Primary Care Case Management - A system under which a PCCM contracts with the state to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid/CHIP recipients.

Primary Care Case Manager (PCCM) - A physician, physician group practice, or entity that employs or arranges with physicians to furnish primary care case management services.

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

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

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

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

Protected Health Information (PHI) - Individually identifiable health that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Part 160 and 164

Provider Agreement - As it pertains to CCNs, the Model Provider Agreement document(s) signed by or on behalf of the CCN entity and those things established or provided for in R.S. 46:437.11-437.14 or by rule, which enrolls the entity in the Medical Assistance Program and grants to the entity provider number and the privilege to participate in the CCN program. It includes the signed Model Provider Agreement document, together with any and all future addendums issued thereto by DHH.

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

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

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

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

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

Readiness Review - Refers to the CCN Enrollment Process in which DHH assesses CCN's ability to fulfill the Provider Agreement requirements. Such review may include but not be limited to review of proper licensure; operational protocols, review of CCN standards; and review of systems. The review may be done as a desk review, on-site review, or combination and may include interviews with pertinent personnel so that DHH can make an informed assessment of the CCN's ability and readiness to render services.

Recipient - An individual entitled to benefits under Title XIX or Title XXI of the Social Security Act, and under the Louisiana Medicaid State Plan who is or was enrolled in Medicaid/CHIP and on whose behalf a payment has been made for medical services rendered.

Registered Nurse (RN) - Person licensed as a Registered Nurse by the Louisiana State Board of Nursing.

Reinsurance - Insurance a CCN purchases to protect itself against part or all of the losses incurred in the process of honoring the claims of members; also referred to as "stop loss" insurance coverage.

Referral Services - Health care services provided to CCN members to both in- and out-of-network when ordered and approved by the CCN, including, but not limited to in-network specialty care and out-of-network services which are covered under the Medicaid program and reimbursed at the fee-for-service Medicaid rate.

Related Party - A party that has, or may have, the ability to control or significantly influence a contractor, or a party that is, or may be, controlled or significantly influenced by a contractor. "Related parties" include, but are not limited to, agents, management employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, contractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.

Relationship - Relationship is described as follows for the purposes of any business affiliations discussed in § 5: A director, officer, or partner of the CCN; A person with beneficial ownership of five percent or more of the CCN's equity; or A person with an employment, consulting or other arrangement (e.g., providers) with the CCN obligations under its contract with the State.

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

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

Risk - The chance or possibility of loss. The member is at risk only for pharmacy copayments as allowed in the Medicaid State Plan and the cost of non-covered services. The CCN, with its income fixed, is at risk for whatever volume of care is entailed, however costly it turns out to be. Risk is also defined in insurance terms as the possibility of loss associated with a given population.

Risk Adjustment - A method for determining adjustments of the PMPM rate that accounts for variation in health risks among participating CCNs when determining per capita prepaid payment.

Routine Care - Treatment of a condition which would have no adverse effects if not treated within 24 hours or that could be treated in a less acute setting (e.g., physician's office) or by the patient.

Routine Primary Care - Routine primary care services include the diagnosis and treatment of conditions to prevent deterioration to a more severe level, or minimize/reduce risk of development of chronic illness or the need from more complex treatment. Examples include psoriasis, chronic low back pain; requires a face-to-face visit within 4 weeks of member request.

Rural Area - Refers to any geographic service area defined by the Office of Management and Budget definition of rural. See Appendix BB for map of Louisiana Rural Parishes of the *CCN-P Policy and Procedure Guide*)

Rural Health Clinic (RHC) - A clinic located in an area that has a healthcare provider shortage that provides primary health care and related diagnostic services and may provide optometric, podiatry, chiropractic and behavioral health services; and which must be reimbursed on prospective payment system.

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

Scope of Services - see "covered services"

Second Opinion - Subsequent to an initial medical opinion, an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service, to assess the clinical necessity and appropriateness of the initial proposed health service.

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Secondary Care - Health care services provided by medical specialists who generally do not have first contact with patients, but instead are referred to them by primary care providers.

Section 1931- Category of Medicaid eligibility for low-income parents who do not receive cash assistance but whose income is below Louisiana's 1996 Aid to Families with Dependent Children income threshold. Louisiana's name for this program is Low Income Families with Children (LIFC)

Secure File Transfer Protocol (SFTP) - Software protocol for transferring data files from one computer to another with added encryption.

Security Rule (45 CFR Parts 160 & 164) -Part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which stipulates that covered entities must maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of their Electronic Protected Health Information against any reasonably anticipated risks.

Service Area - The designated geographical area within which the CCN is authorized by the agreement to furnish covered services to enrollees. A service area shall not be less than one entire parish. Also referred to as geographic service area.

Shall - Denotes a mandatory requirement.

Should- Denotes a preference but not a mandatory requirement.

Significant - As utilized in this Provider Agreement, except where specifically defined, shall mean important in effect or meaning.

Social Security Act - The current version of the Social Security Act of 1935 (42 U.S.C.A. § 301 et seq.) as amended which encompasses the Medicaid Program (Title XIX) and CHIP Program (Title XXI).

Solvency- The minimum standard of financial health for a CCN where assets exceed liabilities and timely payment requirements can be met.

Span of Control - Information systems and telecommunications capabilities that the CCN itself operates or for which it is otherwise legally responsible according to the terms and conditions of the agreement with DHH. The span of control also includes systems and telecommunications capabilities outsourced by the CCN.

Special Health Care Needs Population- An individual of any age with a mental disability, physical disability, or other circumstances that place their health and ability to fully function in

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society at risk, requiring individualized health care requirements.

Specialist/Specialty Services - A specialist/subspecialist is a health care professional who is not a primary care physician.

Start-Up Date - The date CCN providers begin providing medical care to their Medicaid members. Also referred to as “go-live date”.

State - The state of Louisiana.

State Plan - Refers to the Louisiana Medicaid State Plan.

Stratification- The process of partitioning data into distinct or non-overlapping groups.

Subspecialist Services - See **Specialty Services**

Supplemental Security Income (SSI) - A federal program which provides a cash benefit to people who are aged, blind or disabled and who have little or no income or assets Louisiana is a “Section 1634” state and anyone determined eligibility for SSI is automatically eligible for Medicaid.

SURS Reporting - Surveillance and Utilization Review Subsystems is reporting as required in the subsection under Fraud, Abuse and Waste Prevention.

System Availability - Measured within the CCN’s information system span of control. A system is considered not available when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the “enter” or other function key.

Targeted Case Management - Case management for a targeted population of persons paid by state plan. The State Plan defines special needs as: Special Needs is defined as a documented, established medical condition, as determined by a licensed physician, that has a high probability of resulting in a developmental delay or that gives rise to a need for multiple medical, social, educational and other services. In the case of a hearing impairment, the determination of special needs must be made by a licensed audiologist or physician.

Tertiary Care - Highly specialized medical care, usually over an extended period of time than involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities.

Third party liability (TPL) - Refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a State plan.

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Timely - Existing or taking place within the designated period; within the time required by statute or rules and regulations, contract terms, or policy requirements.

Title IV-E - Section of the Social Security Act of 1935 as amended that encompasses medical assistance for foster children and adoption assistance.

Title V - Section of the Social Security Act of 1935 as amended that encompasses maternal child health services.

Title X - Section of the Social Security Act of 1935 as amended that encompasses and governs family planning services.

Title XIX - Section of the Social Security Act of 1935, as amended, that encompasses and governs the Medicaid program.

Title XXI - Section of the Social Security Act of 1935, as amended, that encompasses and governs the Children's Health Insurance Program (CHIP).

TTY/TTD - Telephone Typewriter and Telecommunication Device for the Deaf, which allows for interpreter capability for deaf callers.

Universal Rate - The PMPM rate initially paid to CCNs prior to the first risk adjustment, calculated using fee-for-service (FFS) data for the entire CCN population.

Urban Area - Refers to a geographic area that meets the definition of urban area at § 412.62(f)(1)(ii) which is a Metropolitan Statistical Area(MSA) as defined by the Executive Office of Management and Budget; A list of Louisiana parishes in Metropolitan Statistical Areas can be found at <http://www.doa.louisiana.gov/census/metroareas.htm>

Urgent Care - Medical care provided for a condition that without timely treatment, could be expected to deteriorate into an emergency, or cause prolonged, temporary impairment in one or more bodily function, or cause the development of a chronic illness or need for a more complex treatment. (Examples of conditions that require urgent care include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, suspected fracture; urgent care requires timely face-to-face medical attention within 24 hours of member notification of the existence of an urgent condition.

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

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Validation - The review of information, data, and procedures to determine the extent to which data is accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Voluntary Population - Refers to categories of individuals eligible for, and enrolled in Louisiana Medicaid who are not mandated to enroll in a CCN. By default they will be included in the CCN program, but they may choose to opt out or disenroll at any time.

Waiver - Medicaid Section 1915(c) Home and Community Based Services (HCBS) programs which in Louisiana are New Opportunities Waiver (NOW), Children's Choice, Adult Day Health Care (ADHC), Elderly Disabled and Adult (EDA), Supports Waiver, Residential Options Waiver (ROW), and any other 1915(c) waiver that may be implemented. Participants in waivers are excluded from enrolling in a CCN.

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

Will - Denotes a mandatory requirement.

Willful - Refers to conscious or intentional but not necessarily malicious act.

Appendix B - Louisiana State Plan Services

LOUISIANA STATE PLAN SERVICES						
Services	CMS Classification	Children Age 0 through Age 20	Pregnant*** Women	Adult Ages 21 & Older	Service Limits and/or Prior Authorization	CCN-P Required Services2
Audiology Services	Mandatory	√	√	N/A	√	√
Early, Periodic Screening, Diagnostic and Treatment (EPSDT)	Mandatory	√	√	N/A	√	√
Family Planning	Mandatory	√	√	√	√	√
Federally Qualified Health Center	Mandatory	√	√	√	√	√
Home Health	Mandatory	√	√	√	√	√
Inpatient & Outpatient Hospital Services	Mandatory	√	√	√	√	√
Emergency Room Services	Mandatory	√	√	√	√	√
Lab & X-Ray	Mandatory	√	√	√	√	√
Medical and Surgical Dental Services	Mandatory	√	√	N/A	√	√
Nurse Midwife	Mandatory	√	√	√	√	√
Nursing Facility	Mandatory	√	√	√	√	Not Required
Pediatric and Family Nurse Practitioner	Mandatory	√	√	√	√	√
Personal Care Services (EPSDT)	Mandatory	N/A	N/A	√	√	Not Required
Physician Services	Mandatory	√	√	√	√	√
Pregnancy Related Services	Mandatory	√	√	√	√	√
Rural Health Clinic	Mandatory	√	√	√	√	√
Adult Denture	Optional	N/A	√	√	√	Not Required
Adult Immunizations	Optional	√	√	√	√	√
Ambulatory Surgical Services	Optional	√	√	√	√	√
Behavioral / Mental Health (Non-EPSDT)	Optional	N/A	√	√	√	Basic Level only
Chiropractic Services	Optional	√	N/A	N/A	√	√
Clinic Services*	Optional	√	√	√	√	√
Community Mental Health Services	Optional	√	√	√	√	Not Required
Durable Medical Equipment - Appliances & Supplies	Optional	√	√	√	√	√
Emergency Dental Services	Optional	√	√	√	√	√
End Stage Renal Disease Services	Optional	√	√	√	√	√
Expanded Dental For Pregnant Women	Optional	N/A	√	N/A	√	Not Required
Home Health Extended	Optional	√	N/A	N/A	√	√
Hospice	Optional	√	√	√	√	Not Required
Inpatient Psychiatric Services for Children under 21 and Adults over 65	Optional	√	√	√	√	Not Required
Laboratory and X-ray Services	Optional	√	√	√	√	√
Medical Transportation - Emergency	Optional	√	√	√	√	√
Medical Transportation - Non-Emergency	Optional	√	√	√	√	√
Optometrist (Non-EPSDT)	Optional	N/A	√	√	√	√
Organ Transplants	Optional	√	√	√	√	√
Orthodontia	Optional	√	N/A	N/A	√	Not Required
Personal Care Services (LT-PCS)	Optional	N/A	√	N/A	√	Not Required
Pharmacy	Optional	√	√	√	√	Not Required

LOUISIANA STATE PLAN SERVICES						
Services	CMS Classification	Children Age 0 through Age 20	Pregnant*** Women	Adult Ages 21 & Older	Service Limits and/or Prior Authorization	CCN-P Required Services2
Podiatry	Optional	√	√	√	√	√
Prosthetic & Orthotic Devices	Optional	√	√	√	√	√
Rehabilitative Services **	Optional	√	√	√	√	√
Targeted Case Management	Optional	√	√	√	√	Not Required
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.

***Shall provide pregnancy-related services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of being pregnant and includes but is not limited to prenatal care, delivery, postpartum care, and family planning service for pregnant women in accordance with 42 CFR Part 440 Subpart B

Appendix C

Performance Measures

Louisiana Administrative Performance Measurement Set

Measure	Minimal Performance Standard
Call Abandonment Rate	≥ 95%
Average Speed of Answer	30 seconds
Percentage of Calls answered within 30 seconds	≥90%
Total Complaints Resolved with 30 days	≥99%
Claims paid within 30 days	100%
Rejected claims returned to provider with reason code within 15 days of receipt of claims submission	≥99%
Claims Paid Financial Accuracy	≥99%
Claims Paid Processing Accuracy	≥97%

Louisiana Performance Measurement Set for Pediatric Networks

** Type of measure \$\$ Measures associated with incentives/disincentives

Access and Availability of Care	Effectiveness of Care		Use of Services	Prevention Quality Indicators	Satisfaction and Outcomes
\$\$Children and Adolescents Access to PCP ** HEDIS/CHIPRA	Childhood Immunization Status **HEDIS/CHIPRA	\$\$ Chlamydia Screening in Women **HEDIS/CHIPRA	Well-Child Visits in the First 15 Months of Life **HEDIS/CHIPRA	\$\$Inpatient Hospital Readmission Rate within 30 Days **State	\$\$ CAHPS Health Plan Survey 4.0, Child Version including Children With Chronic Conditions **HEDIS/CHIPRA
	\$\$ Immunizations for Adolescents **HEDIS/CHIPRA	\$\$ Lead screening in children **HEDIS	\$\$ Well-Child Visits in the Third, Fourth, Fifth and Sixth of Life **HEDIS/CHIPRA		Provider Satisfaction **State
	Follow-Up Care for Children Prescribed ADHD Medication **HEDIS/CHIPRA	\$\$ Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents **HEDIS/CHIPRA	\$\$ Adolescent Well-Care Visits **HEDIS/CHIPRA		
	ABCD Initiative Measures **CHIPRA	Appropriate Testing for Children With Pharyngitis **HEDIS/CHIPRA	\$\$ Ambulatory Care (ER Utilization) **HEDIS		
	HgbA1C testing in all children and adolescents diagnosed with diabetes **CHIPRA	Use of Medication for people with Asthma **HEDIS/CHIPRA	Emergency Utilization-Avg # of ED visits per member per reporting period **CHIPRA		
	Otis Media Effusion **CHIPRA		Annual # of asthma patients (1yr old) with 1 asthma related ER visit **CHIPRA		

Louisiana Performance Measurement Set for Adult Networks

** Type of measure \$\$ Measures associated with incentives/disincentives

Access and Availability of Care	Effectiveness of Care	Use of Services	Prevention Quality Indicators	Satisfaction and Outcomes
\$\$Adults' Access to Preventive/ Ambulatory Health Services ** HEDIS	Breast CA Screening **HEDIS/CHIPRA	\$\$ Chlamydia Screening in Women **HEDIS/CHIPRA	Adult Well-Care Visits **State	\$\$ Adult Asthma Admission Rate **AHRQ \$\$ CAHPS Health Plan Survey 4.0, Adult Version **HEDIS
Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care) **HEDIS/CHIPRA	Cervical CA Screening **HEDIS	\$\$ Percent of live births weighing less than 2,500 grams **CHIPRA	\$\$ Ambulatory Care (ER Utilization) **HEDIS	\$\$ CHF Admission Rate **AHRQ Provider Satisfaction **State
	\$\$ Comprehensive Diabetes Care **HEDIS	Cesarean Rate for Low-Risk First Birth Women **CHIPRA	Frequency of Ongoing Prenatal Care **HEDIS/CHIPRA	\$\$ Uncontrolled Diabetes Admission Rate **AHRQ
	Controlling High Blood Pressure **HEDIS	Use of Medication for people with Asthma **HEDIS/CHIPRA		\$\$ Inpatient Hospital Readmission Rate within 30 Days **State
	Total number of eligible women who receive 17-OH progesterone during pregnancy, and percent of preterm births at fewer than 37 weeks and fewer than 32 weeks in those recipients. ** State	% of Pregnant women who are screened for tobacco usage and secondhand smoke exposure and is offered an appropriate and individualized intervention. ** State		

Louisiana Performance Measurement Set for Adult/Pediatric Networks

Access and Availability of Care	Effectiveness of Care		Use of Services	Prevention Quality Indicators	Satisfaction and Outcomes
\$\$ Adults' Access to Preventive/ Ambulatory Health Services ** HEDIS	Childhood Immunization Status **HEDIS/CHIPRA	\$\$ Chlamydia Screening in Women **HEDIS/CHIPRA	Well-Child Visits in the First 15 Months of Life **HEDIS/CHIPRA	Adult Asthma Admission Rate **AHRQ	CAHPS Health Plan Survey 4.0, Adult Version **HEDIS
Children and Adolescents Access to PCP ** HEDIS/CHIPRA	Immunizations for Adolescents **HEDIS/CHIPRA	\$\$ Percent of live births weighing less than 2,500 grams **CHIPRA	\$\$ Well-Child Visits in the Third, Fourth, Fifth and Sixth of Life **HEDIS/CHIPRA	CHF Admission Rate **AHRQ	\$\$ CAHPS Health Plan Survey 4.0, Child Version including Children With Chronic Conditions **HEDIS/CHIPRA
Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care) **HEDIS/CHIPRA	\$\$ Lead screening in children **HEDIS	Cesarean Rate for Low-Risk First Birth Women **CHIPRA	\$\$ Adolescent Well-Care Visits **HEDIS/CHIPRA	Uncontrolled Diabetes Admission Rate **AHRQ	Provider Satisfaction **State
	Cervical CA Screening **HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents **HEDIS/CHIPRA	Adult Well-Care Visits **State	\$\$ Inpatient Hospital Readmission Rate within 30 Days **State	
	Breast CA Screening **HEDIS/CHIPRA	Appropriate Testing for Children With Pharyngitis **HEDIS/CHIPRA	\$\$ Ambulatory Care (ER Utilization) **HEDIS		
	Controlling High Blood Pressure **HEDIS	Use of Medication for people with Asthma **HEDIS/CHIPRA	Emergency Utilization-Avg # of ED visits per member per reporting period **CHIPRA		
	Follow-Up Care for Children Prescribed ADHD Medication **HEDIS/CHIPRA	\$\$ Comprehensive Diabetes Care **HEDIS	Annual # of asthma patients (1yr old) with 1 asthma related ER visit **CHIPRA		
	Otis Media Effusion **CHIPRA	HgbA1C testing in all children and adolescents diagnosed with diabetes **CHIPRA	Frequency of Ongoing Prenatal care **HEDIS/CHIPRA		
	ABCD Initiative Measures **CHIPRA	Total number of eligible women who receive 17-OH progesterone during pregnancy, and percent of preterm births at fewer than 37 weeks and fewer than 32 weeks in those recipients. ** State			
		% of Pregnant women who are screened for tobacco usage and secondhand smoke exposure and is offered an appropriate and individualized intervention. ** State			

****** Type of measure **\$\$** Measures associated with incentives/disincentives

Appendix D

HIPAA Business Associate Appendix

HIPAA BUSINESS ASSOCIATE APPENDIX

A. Purpose

The Louisiana Department of Health and Hospitals (Covered Entity) and CCN (Business Associate) agree to the terms of this Appendix 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 Provider Agreement 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

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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 Provider Agreement.
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 Provider Agreement or as required by law.
2. Use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for in the Provider Agreement.
3. Mitigate to the extent practicable, any harmful effect known to Business Associate if it uses/discloses PHI in violation of the Provider Agreement.
4. Notify Covered Entity of any actual or suspected breaches in privacy or security that compromise PHI. Notification of security and/or privacy breaches should be given to:

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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

Business Associate shall give initial notification immediately upon its discovery of a breach, but in no event later than one (1) business day after discovery. The initial notification shall include all relevant information which is known and available to Business Associate at that time.

Business Associate shall provide a detailed description of the breach to Covered Entity within five (5) business days after discovery, except when despite all reasonable efforts by Business Associate to obtain the information required, circumstances beyond its control necessitate additional time. Under such circumstances, Business Associate shall provide the detailed description to Covered Entity as soon as possible and without unreasonable delay, but in no event later than fifteen (15) business days after the discovery of a breach. The detailed description shall include, at a minimum:

- a. The date of the breach;
- b. The date of the discovery of the breach;
- c. A description of the types of PHI that were involved;
- d. Identification of each individual whose PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed;
- e. Any measures that have been taken by the Business Associate to mitigate the breach; and
- f. Any other details necessary to complete an assessment of the risk of harm to the individuals affected by the breach.

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If Business Associate fails to give initial notification of a breach to DHH within one (1) business day after it discovered or should have discovered the breach, DHH may impose monetary penalties of \$300 per day from the date that the Business Associate should have given initial notification to the date that DHH becomes aware of the breach.

DHH may impose monetary penalties 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 Appendix.
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 Appendix, 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 Provider Agreement, Business Associate may use PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Provider Agreement, 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 Appendix, in the Provider Agreement or required by law, Business Associate may not disclose/re-disclose PHI except to Covered Entity.
2. Except as limited in this Appendix, 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 Provider Agreement.

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3. Except as limited in this Appendix, 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 Appendix shall be effective immediately upon signing of both the Provider Agreement and this Appendix, 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.

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2. Upon its knowledge of a material breach by Business Associate, Covered Entity shall either:
 - a. Allow Business Associate to cure the breach or end the violation and terminate the Provider Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; or
 - b. Immediately terminate the Provider Agreement if Business Associate has breached a material term of this Appendix and cure is not possible; or
 - c. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

3. Effect of Termination

- a. Except as provided in paragraph (b) below, upon termination of the Provider Agreement, 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 Appendix 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

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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 Appendix to a section in the Privacy Rule means the section as in effect or as amended.
2. The Parties agree to amend this Appendix 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 Provider Agreement.
4. Any ambiguity in this Appendix 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 E: UNIVERSAL PMPM RATE SCHEDULE

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