Medicaid Coordinated Care Networks – Shared Savings (CCN-S)

Policy and Procedure Guide

September 7, 2010

CCN-S Policy and Procedure Guide

Documentation change control is maintained in this Guide using the Change Control Table shown below. All changes made to this Guide after the creation dates are noted along with the author, date, and reason for the change.

Change Control Table

Author of Change	Sections Changed	Description	Reason	Date
DHH	Guide	Contents	Version 1	Sept 2010

TABLE OF CONTENTS

1 Introduction 1-3

2 CCN Provider Agreement Enrollment Process 4-19

Service Areas 4
Implementation Schedule 6
Sequence of Application Review 16
Provider Network Adequacy Determination Process 17
CCNs Approved Model Contract Changes 18
Designated Service Area Provider Network Approval Process 18

3 CCN Requirements 20-24

General Provisions 20
Hours of Operation 21
Provider Relations 22
Network Provider Development and Management Plan 22
Network Changes 23
Record Retention 24

4 Access Standards and Guidelines 25-30

Assurance of Adequate Access and Capacity 25
Access to Primary Care Providers 25
Timely Access 27
Other Access Requirements 27
Direct Access Women's Health Care 27
Second Opinion 28
Office of Public Health 28
Coordination with Other Service Providers 28
Cultural Competency 28
Patient-Centered Medical Home 28

5 Member Enrollment 31-41

Enrollment Populations 31
Enrollment Process 31
Enrollment Broker – Enrollment Responsibilities 31
Enrollment Counseling 31
Accessibility of Enrollment Process 32
Distribution of CCN's Enrollment Materials 32
Notification of Availability of CCNs to Eligibles 32

Selection of a CCN....32
CCN Enrollment Responsibilities....33
Policies and Procedures for Eligible Medicaid/CHIP Eligibles....33
Acceptance of All Eligibles....33
Change of Status....34
New Member Orientation....34
Choice of Providers....34
Assignment of Primary Care Provider....34
Enrollment Updates....35
Reconciliation....35
Services for New Members....36
Transition of Existing CommunityCARE Enrollees....36
New Medicaid/CHIPEligibles....36
Annual Open Enrollment....38
Eligibility Period....38
PCP Selection....38
Discrimination....39
Automatic Assignment Methodology....39
Automatic Assignment to CCN....39
PCP Automatic Assignment by CCN....40
Lock-In Period....40
Enrollment Updates....40
Reenrollment....41

6 Member Disenrollment....42-44

Involuntary Disenrollment Request by CCN for Cause....42
Request by the Member....43
Procedures....43
Disenrollment for Cause....43
Departmental Action on Request....43
Action of Disenrollment Request....44
Timeframe for Disenrollments....44

7 Other Member Enrollment and Disenrollment Requirements....45-47

Notifications....45
Transition....46
Between CCNs....46
Changing PCPs....47
Reporting....47

8 Enhanced Primary Care Case Management Services....48-81

General Provisions....48

Behavioral Health Services 49
Carved-Out Services 50
Federally Qualified Health Centers 51
Preventive and Safety Educational Programs/Activities 51
Prohibited or Excluded Services under the Louisiana Medicaid Program 51
Women's Health Services 52
Early and Periodic Screening, Diagnosis and Treatment 52
Care Management 52
- Referrals 53
- Care Coordination, Continuity of Care and Care Transition 53
  - Continuity of Care for Pregnant Women 55
  - Continuity of Behavioral Health Care 55
  - Continuity for DMEPOS 56
  - Care Transition 57
- Utilization Management 58
  - Service Authorization 61
  - Timing of Service Authorization Decisions 62
  - Notice of Action 63
  - Medical History Information 63
  - Exceptions to Service Authorizations and/or Referrals Requirements 63
  - PCP Utilization and Quality Profiling 64
  - PCP Utilization and Quality Profiling Reporting Requirements 65
- Case Management 65
  - Case Management Functions 66
  - Case Management Policies and Procedures 66
  - Identifying Special Populations 68
  - Case Management Reporting Requirements 68
- Chronic Care Management Program 69
  - Chronic Care Management Program Policies and Procedures 69
  - Predictive Modeling 70
  - Chronic Care Management Reporting Requirements 71
- Quality Management 71
  - QAPI Committee 71
  - QAPI Plan 72
  - QAPI Reporting Requirements 72
  - Performance Measures 73
  - Performance Measurement Goals 74
  - Performance Measure Reporting Requirements 75
  - Performance Improvement Projects 75
  - PIP Reporting Requirements 78
  - Pay for Performance 78
  - Member Satisfaction Surveys 78
  - Provider Satisfaction Surveys 79

Department Oversight 79
External Independent Review 80

9 General CCN and Network Provider Responsibilities and Requirements 82-88

Contract Requirements 82
Physician Incentive Plans 84
CCN Network Provider's Dispute Resolution 84
Provider-Member Communication Anti-Gag Clause 84
Self-Referrals 88
Provider Handbooks 85
Education and Training 87
Provider Complaint System 87
Provider Access Component of Toll-free Telephone line 88
TPL Reporting 88

10 Member Rights and Responsibilities 89-95

Member Welcome Packets and Calls 89
Member ID Cards 90
Member Call Center 90
Member Service Call Center 90
Call Center Hours of Operation 91
Automated Call Distribution System 91
Performance Standards 92
Provider Directory for Members 92
Additional Member Educational Materials and Programs 93
Health Care Cost and Quality Transparency 94
Member Rights 94
Member Responsibilities 94
Notice to Members about Provider Termination 95

11 Grievance and State Fair Hearings 96-101

General Requirements 96
CCN Grievance Process 98
Oral Grievances 98
Written Grievances 109
DHH State Fair Hearing Process 100

12 Marketing and Outreach 102-113
Marketing Definitions 102
Prohibited Marketing Activities 102
Allowable Activities 105

Reporting Alleged Marketing Violations 106
CCN Provider Recruitment Guidelines 107
CCN Provider Recruitment Material Review Process 107
CCN Providers and Marketing 108
Marketing Representatives 109
State Approval of Materials 110
Approval Process 111
Website Requirements 112

13 System and Technical Requirements 114-132

Data and Document Management Requirements 114
Adherence to Standards 114
Confidentiality, Privacy and Security 114
System Accessibility 114
Data and Document Relationship 115
Retention 115
Information Ownership 116
System and Data Integration Requirements 116
Adherence to Standards for Data Exchange 116
HIPAA Compliance 117
Connectivity and Interoperability 117
Program Integrity (Fraud and Abuse) 118
Preprocessed Claims Data Submission 119
Eligibility and Enrollment Data Exchange 120
Provider Files 120
System, Information Security and Access Management 121
System Availability 123
Contingency Plan 124
Off Site Storage and Remove Back-up 125
System User and Technical Support Requirements 126
System Testing and Change Management Requirements 127
Information Systems Documentation Requirements 128
Systems Function Reporting Requirements 128
Electronic Messaging 129
Address Standardization 130
Electronic Medical Records 130
Statewide Health Information Exchange 130
HIPAA-Based Formatting Standards 130
Audit Requirements 130
Systems Refresh Plan 131
Termination Transition Plan 131

14 Claims Management 133-136

General Provisions....133
CCN-Service Authorization Responsibilities....133
FI – Service Authorization Responsiblities....134
FI – Prompt Payment Responsiblities....134
Claims Formats....135
Service Authorization Disputes....135
Remittance Advices and Related Functions....136
Payment Cycles....136

15 Reimbursement....137-138

CCN Reimbursement....137
Provider Reimbursement....137
Health-Based Risk Adjustment Methodology....138

16 Financial Information....139-143

Federal Financial Participation....139
Access to Records, Books, and Documents....139
Audit of Services, Deliverables, and Inspections....140
Louisiana Legislative Auditor's Audit....140
Report Transactions....141
Insolvency....142
Financial Solvency....142
Other Requirements....143
Charitable Donations....143

17 Fraud, Abuse and Waste Prevention....144-150

General Requirements....144
Fraud and Abuse Compliance Plan....144
Prohibited Affiliations....146
Excluded Providers....147
Reporting....147
Service Verification....148
State Conflict of Interest Safeguards....148
Whistleblower Protections....148
Medical Records....118

18 Sanctions and Dispute Resolution....151-161

General Provisions....151
Administrative Actions....151
Monetary Penalties....152

Intermediate Sanctions....152
Suspension of Enrollment....152
Withhold Payment....152
Recovery of Monies....153
Corrective Action Plans....153
Imposition and Extent of Sanctions....154
Imposition of Sanctions....154
Scope of Sanctions....155
Misconduct for which Sanctions May be Imposed....155
Federal Sanctions....158
Remedial Actions....158
Maintaining Financial and Operational Capacity....159
Notice of Action....159
Right to an Informal Meeting....159
Right to Request Dispute Resolution Conference....160
Termination of Provider Agreement....160
Attorney Fees....161

19 Additional Terms and Conditions....162-169

Additional Requirements for CCN Contracts with Other Parties....162
Ownership and Management Disclosure....165
Termination Procedures....167
Withdrawing Services from a Parish or Service Area....167
Board Resolution/Signature Authority....168
Warranty to Comply with State and Federal Regulations....1687
Warranty of Removal of Conflict of Interest....168
Emergency Management Plan....168

20 Readiness Review....170-174

21 Reporting....175-180

APPENDICES

A Definitions....181

B Louisiana Medicaid State Plan Services....206

C Performance Measures....209

D Performance Improvement Projects....214

E Attestation of Provider Network....216

F DHH Administrative Region Map 218

G Member's and Potential Member's Bill of Rights 220

H Certification Letter of Actuarial Soundness of PMPM Rates 224

I Guidelines for Involuntary Member Disenrollment 226

J Provider Bill of Rights 229

K Model Attestation Letter 231

L Grievance Reporting Requirements 233

M Rules Regarding Physician Incentive Plans 239

N CCN Disenrollment Report 241

O Marketing Guidelines 243

P CCN Initiated Disenrollment Request 247

Q Coordination of CCN Fraud and Abuse Complaints and Referrals 249

R Readiness Review Agreement 253

S Person First Policy 255

T Louisiana Map of Rural Parishes 260

U Marketing Plan Monthly Report 262

V TPL Notification Traditional Medicare Form 264

W TPL Notification Traditional Medicaid Form 267

X Fiscal Intermediary Payment Schedule 270

Y Provider Contractor Spreadsheet Requirments 272

Z Marketing Complaint Form 274

AA Marketing Event Submission Form 276

BB Marketing Material Submission Form 278

CC OPH/CCN Memorandum of Understanding 280

SECTION 1 - INTRODUCTION

Background

The mission of the Louisiana Department of Health and Hospitals (hereafter referred to as "DHH") is to protect and promote health and to ensure access to medical, preventative, and rehabilitative services for all citizens of the state of Louisiana. DHH is dedicated to fulfilling its mission through direct provision of quality services, the development and stimulation of services by others and the utilization of available resources in the most effective manner.

DHH is comprised of the Bureau of Health Services Financing (BHSF) and four program offices which are: Office of Aging and Adult Services (OAAS), Office for Citizens with Developmental Disabilities (OCDD), Office of Behavioral Health (OBH), and the Office of Public Health (OPH). Under the general supervision of the Secretary, these principle offices perform the primary functions and duties assigned to DHH.

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

BHSF is the agency within DHH responsible for the administration of the program of medical assistance under Title XIX of the Social Security Act known as the Medicaid Program and the program of medical assistance under Title XXI of the Social Security Act known as the Children's Health Insurance Program (CHIP). The United States Department of Health and Human Services allocates funds under Title XIX and Title XXI to DHH for the provision of medical services for eligible persons in accordance with the Louisiana State Plan for Medical Assistance, herein referred to as the State Plan.

Following the guidance of the Louisiana Legislature and the Louisiana Health Care Reform Act of 2007, DHH is transitioning from the current fee-for service delivery system (which rewards volume over value) to integrated care models that place accountability on the provider in DHH's Coordinated System of Care Program. Authority for DHH to institute needed reform to Louisiana's Medicaid Coordinated System of Care Program is contained in Act 243 of the 2007 Regular Session of the Louisiana Legislature. This legislation directs DHH "to lead the initiative to improve health outcomes in Louisiana via the development and implementation of a patient-centered medical home system of care for Medicaid enrollees….." The legislation requires that the reformed program encompass the following:

- Safe, patient-centered, evidence based, accessible, and sustainable care;
- Convenient and comprehensive primary care with a coordinated continuum of care;
- Access to appropriate specialty care and inpatient services;
- Mechanisms to reduce the disparities in access to health care among the State's populations;
- Quality driven and cost-effective health care;

- Strong and effective medical management with both patient and provider accountability;
- Mandatory adoption of interoperable electronic medical records; and
- Reimbursement levels sufficient to ensure provider participation and success with enhanced reimbursement methodology for participating providers, incorporating features of successful coordinated care programs.

DHH has defined its mission in the Coordinated System of Care Program as 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. The State intends to promote and further its mission by defining measurable results that will improve Medicaid and CHIP enrolled individuals' access and satisfaction, maximize program efficiency, effectiveness, and responsiveness, and reduce operational and service costs. The following methods are intended to support the achievement of this mission:

- Provide a patient-centered medical home for Medicaid and CHIP eligibles to promote continuity of care;
- Emphasize prevention and self-management to improve quality of life;
- Supply providers and members with evidence-based information and resources to support optimal health management; and
- Utilize data management and feedback to improve health outcomes for the state.

It is the intent of DHH to attain this mission by enrolling eligible Medicaid and CHIP eligibles in the Prepaid Coordinated Care Networks and Shared Savings Coordinated Care Networks. The Coordinated Care Network Program (hereafter referred to as Coordinated Care Program) is a healthcare system offering the full continuum of health care services as defined by the Provider Agreement. The Shared Savings Coordinated Care Network, herein referred to as CCN-S, is defined as a primary care case manager (PCCM) that has been approved and enrolled as a Medicaid provider by the Department of Health and Hospitals to provide enhanced primary care case management, in addition to contracting with primary care providers (PCPs) for care management, of Medicaid and CHIP eligibles in return for a enhanced primary care case management rate paid on a per member, per month (PMPM) basis.

Implementation of the Coordinated Care Program is expected to yield a broad range of benefits affecting all Louisiana citizens. The state anticipates an improved report card on overall health quality as the direct result of improved quality in the health care it delivers to its citizens. The new measures will be a bold step toward readiness for the major influx of new adult Medicaid eligibles subsequent to national health reform's expansion of eligibility to adults having income at or below 133% of the Federal Poverty Level (FPL). Savings and a more predictable budget have been the experience in other states that have implemented similar models. CCNs may provide financial incentives to their network providers for meeting standards of quality care.

Purpose and Oversight

The purpose of this ***Shared Savings Coordinated Care Network Policy and Procedure Guide***, herein referred to as ***Guide***, is to document program policies and requirements to be implemented by CCN-Ss in the Medicaid Coordinated Care Program.

The Medicaid Coordinated Care Section (MCCS), located within DHH's Bureau of Health Services Financing, is responsible for the formulation of medical and program policy, interpretation of these policies and oversight of quality and utilization management requirements set forth in this Guide. CCNs in need of assistance to locate, clarify, or interpret medical or program policy should contact MCCS at the following address:

Medicaid Coordinated Care Section
Department of Health and Hospitals
Post Office Box 91030
Baton Rouge, Louisiana 70821 - 9030
Fax: (225) 376-4700
Phone: (225) 342-1304
coordinatedcarenetworks@la.gov

Requests to add or modify or delete standards, criteria or requirements related to current medical or program policy should be forwarded to MCCS.

LEFT BLANK INTENTIONALLY

SECTION 2 – CCN PROVIDER AGREEMENT ENROLLMENT PROCESS

This section of the ***Guide*** is designed to provide information necessary for preparing to initiate a CCN-S Provider Agreement with DHH. DHH will furnish potential CCNs with an electronic copy of the model Provider Agreement in Microsoft Word upon request. If a potential CCN electronically accepts the model Provider Agreement, the CCN acknowledges and accepts full responsibility to insure that no changes are made to the model Provider Agreement. In the event of a conflict between a version of the model Provider Agreement in the CCN's possession and DHH's version of the model Provider Agreement, DHH's version shall govern.

The Provider Agreement may also be found on the DHH website at www.MakingMedicaidBetter.com. The terms of the Provider Agreement are established and are not negotiable. The enrollment of CCNs into the CCN program will be conducted continuously or as deemed necessary by DHH.

Service Areas

The minimum geographic service area for which a CCN may submit a Provider Agreement shall be one entire parish; this area is herein referred to as "service area". A CCN must provide services for the entire parish for each parish chosen. The CCN may serve more than one parish in a region and multiple regions. Preference in the automatic assignment process will be given to CCNs that include all parishes within a region in their service area. Parishes in DHH's Administrative Regions are:

- Region 1:
  - Jefferson
  - Plaquemines
  - Orleans
  - St. Bernard

- Region 2:
  - Ascension
  - East Baton Rouge
  - East Feliciana
  - Iberville
  - Point Coupee
  - West Baton Rouge
  - West Feliciana

- Region 3:
  - Assumption
  - Lafourche
  - St. Charles
  - St. John

  - St. James
  - St. Mary
  - Terrebonne

- Region 4:
  - Acadia
  - Evangeline
  - Iberia
  - Lafayette
  - St. Landry
  - St. Martin
  - Vermillion

- Region 5:
  - Allen
  - Beauregard
  - Cameron
  - Calcasieu
  - Jefferson Davis

- Region 6:
  - Avoyelles
  - Catahoula
  - Concordia
  - Grant
  - LaSalle
  - Rapides
  - Vernon
  - Winn

- Region 7:
  - Bienville
  - Bossier
  - Caddo
  - Claiborne
  - DeSoto
  - Natchitoches
  - Red River
  - Sabine
  - Webster

- Region 8:
  - Caldwell
  - East Carroll

  - Franklin
  - Jackson
  - Lincoln
  - Madison
  - Morehouse
  - Ouachita
  - Richland
  - Tensas
  - Union
  - West Carroll

- Region 9:
  - Livingston
  - St. Helena
  - St. Tammany
  - Tangipahoa
  - Washington

Implementation Schedule

DHH will notify all potential CCNs via DHH's www.MakingMedicaidBetter.com website of the deadline of December 1, 2010 for phase one of implementation to have an on-site readiness review schedduled to assure first market entry for the provision of services in DHH's Administrative Regions 1 – 9 (See Appendix F – DHH Administrative Region Map). Implementation of the CCN program will be phased-in based on DHH's Administrative Regions and is scheduled to begin in April 2011 with regional phase in as follows:

- Phase 1 – Regions 2, 3 and 9;
- Phase 2 – Regions 1, 7 and 8; and
- Phase 3 – Regions 4, 5 and 6.

DHH will enter into a CCN-S Provider Agreement with any CCN that:

- Meets the PCCM definition as defined in 42 CFR §438.2;
- Is certified by the Louisiana Secretary of State to do business in the State of Louisiana;
- Is licensed by the Louisiana Department of Insurance as a Medical Necessity Review Organization (MNRO) or contracts with a MNRO;
- Has the capability to pre-process claims and transfer data or contracts with an entity to perform these functions; and
- Agrees to and complies with all the terms and conditions of the Provider Agreement.

The CCN shall be required to successfully complete the following steps in CCN Enrollment Process. Steps are as follows:

- Step 1 – Submission of Signed Provider Agreement and Required Documents to Formally Initiate the Enrollment Process
- Step 2 – **Readiness Review** – Submission of Additional Documents Prior to On-Site Review
- Step 3 – **Readiness Review** – MMIS & Enrollment Broker Connectivity
- Step 4 – **Readiness Review** - On-Site Review at Louisiana location
- Step 5 – **Readiness Review** – Determination of Adequacy of Network
- Step 6 – DHH Approval and Submission of Provider Agreement to CMS for Approval
- Step 7 – Provider Agreement is Finalized and Sent to CCN
- Step 8 – Issuance of Medicaid CCN Provider Number

The CCN must successfully complete all steps of the enrollment process, some which may be concurrent, to be enrolled and issued a CCN Medicaid provider number. MCCS will notify the CCN in writing when each step has been successfully completed.

During the initial phase-in of the CCN program, DHH cannot guarantee a CCN will meet the first market entry time table if submissions/information received are not complete and accurate and received within the time frames specified by DHH.

If deficiencies are noted during the CCN enrollment process, the CCN will be notified of the timeframe to submit a Corrective Action Plan (CAP) to MCCS for approval. MCCS will monitor the CCN's progress with the CAP. The time frame(s) for correcting deficiency(ies) will be based on the severity and scope of the deficiency(ies).

- The following are the requirements for each step in the CCN Enrollment Process

STEP 1: Submission of Letter of Intent, Signed Provider Agreement and Required Documents to Formally Initiate the Enrollment Process

A. The potential CCN shall submit a *Letter of Intent to Enroll* in the Coordinated Care Program which includes:

1) Name and contact information for personauthorized to represent the CCN during the enrollment process ;
2) Proposed service areas; and
3) Maximum Medicaid/CHIP enrollment per implementation phase addressed to:

Ruth Kennedy
Medicaid Deputy Director
Louisiana Department of Health and Hospitals

Bureau of Health Services Financing
628 North 4th Street
Post Office Box 91030
Baton Rouge, Louisiana 70821- 9030
Phone: (225) 342-2699
Fax: (225) 376-4808

Email: Ruth.Kennedy@la.gov

B. Completed Application for Enrollment forms which include:

1. Complete Medicaid CCN-P PE 50 Enrollment Packet
   a. Disclosure of Ownership & Controlling Interest StatementForm
   b. Medicaid Direct Deposit (EFT) Authorization Agreement

2. Two (2) signed copies of Provider Agreement
3. Form W-9, Taxpayer Identification Number and Certification (http://www.irs.gov/pub/irs-pdf/fw9.pdf?portlet=3)

The CCN may access copies of the above forms in the CCN Enrollment Packet from the www.MakingMedicaidBetter.com website.

C. Required Submissions

The following additional items/documents must be submitted in Step 1 of the CCN Enrollment Process. The CCN shall provide three (3) hard copies of the Required Submissions. All documents must be labeled and in the order of each section and subsection specified below. The CCN shall also simultaneously provide the documents electronically (in pdf format) and as specified for the hard copy documents.

The CCN shall comply with **all** appropriate Provider Agreement requirements for each required submission.

1. Organizational Requirements

a. A copy of Ownership and Controlling Interest Statement. Organizational documents (partnerships, incorporations, etc.) Form CMS 1513 (02/09). (§3.8 of the Provider Agreement)

b. Certification by the Louisiana Secretary of State to do business in Louisiana.

c. A copy of Medical Necessity Review of Organization (MNRO) license from the Louisiana Department of Insurance (DOI) **or** a copy of the application for licensure submitted to the Louisiana

Department of Insurance or a letter of intent to contract with a Louisiana DOI licensed/authorized MNRO. See DOI website: http://www.ldi.state.la.us/Documents/Licensing/Company/MNROApplication

d. Signed Readiness Review Agreement (Appendix R).

e. Signed HIPAA Business Associate Appendix (See Appendix E of the Provider Agreement).

f. Trade name certificate issued by the Secretary of State of Louisiana. This item must be supplied by any applicant utilizing a trade name in Louisiana.

g. Proof of coverage of:
   i. Workers' Compensation (See §2.2 of the Provider Agreement)
   ii. Commercial Liability Insurance (See §2.3 of the Provider Agreement)
   iii. Errors and Omissions Insurance (See §2.10 of the Provider Agreement)

2. Contract Requirements

a. A copy of Model Contracts for each health-care provider type and any contract for which the CCN has delegated its responsibilities to a contractor. (e.g. pre-processing, MNRO) (**§ 5.1** of the Provider Agreement – *Contract Requirements*)

3. Service Delivery Requirements

a. A listing of proposed parish(es) (**Service Area**) for the provision of enhanced primary care case management. (**§ 4.12** of the Provider Agreement – *Designated Service Area*)

b. A signed copy of Appendix E – **Attestation of Provider Network Submission**

4. Enrollment

An attestation of the CCN's maximum Medicaid/LaCHIP member enrollment (projected) capacity. (**§ 6.12** of the Provider Agreement – *Tracking Linkage Availability*)

The Medicaid Coordinated Care Section (MCCS) will review the Required Submissions internally. MCCS will notify the CCN of any changes or re-submissions that must be made.

STEP 2: Readiness Review – Submission of Documents Prior to On-Site Review

The following additional items/ documents must be submitted in Step 2 of the CCN Enrollment Process. The CCN shall provide three (3) hard copies of the Required Submissions. All documents must be labeled and in the order of each section and subsection specified below. The CCN shall also simultaneously provide the documents electronically (in pdf format) and as specified for the hard copy documents.

The Provider Agreement sections indicated are intended as a guide only and may not be the only Provider Agreement requirements related to the required submission listed. This information is being provided as a guide only and does not relieve the CCN from complying with **all** appropriate Provider Agreement requirements for each required submission.

1. **Current or Pending Administrative Legal Actions or Grievances by Contractor/Member Summary**

   A summary of any current or pending administrative legal action(s) or grievance(s) filed by contractor/member, including the dates of initiation and resolution as specified in **§ 5.1.35** of the Provider Agreement; along with a copy of each action or grievance. If there are no current or pending administrative legal actions(s) or grievance(s), the CCN shall stipulate in writing to DHH.

2. **Current or Pending Administrative Legal Actions or Grievances of Persons Convicted of Criminal Offense Summary**

   A summary of any current or pending administrative legal action(s) or grievance(s) of person(s) convicted of criminal offense, including the dates of initiation and resolution; along with copy of each or grievance (**§ 10.10** of the Provider Agreement). If there are no current or pending administrative legal actions(s) or grievance(s), the CCN shall stipulate in writing to DHH.

3. List of Staff Liaisons

A list of staff liaisons including the Name, Title, and Telephone Number, and E-Mail Address of the designated individual for the following: (**§ 3.3** of the Provider Agreement)

a. Liaison Staff Contact
b. Medical Director Contact
c. Senior Management Contact
d. Quality Assurance Contact
e. Reporting Contact

4. Proof of Coverage

a. Worker's Compensation (See **§2.**2 of the Provider Agreement)
b. Commercial Liability Insurance (See **§2.3** of the Provider Agreement)
c. Errors and Omissions Insurance (See §2.10 of the Provider Agreement)

5. Proof of Bond Coverage

a. Performance Bond (See **§2.4** of the Provider Agreement)
b. Fidelity Bond (See **§2.8** of the Provider Agreement)

6. Quality Assessment and Performance Improvement

a. A copy of Quality Assessment and Performance Improvement (QAPI) policy and procedures in accordance with 42 CFR Part 438 requirements.

b. A copy of Chronic Care Management Program policy and procedures, including predictive modeling methodology as specified this ***Guide***.

7. Marketing

a. A copy of the CCN's written Marketing Plan and Materials, including evidence of coverage and enrollment materials, recipient education materials, member handbook, grievance materials, a sample or copy of the member ID card(s) and advertising materials. (Provider Agreement **§ 7.2** – Approval of

Marketing Plan and Materials. See Marketing, Member Education and Enrollment section of this ***Guide***)

b. A copy of all proposed CCN's provider recruitment materials. (See Section 12 – Marketing and Outreach of this ***Guide***)

8. Fraud and Abuse Compliance Plan

A copy of the administrative and management arrangements or procedures, including a mandatory Fraud and Abuse Compliance Plan**,** that are designed to guard against fraud and abuse and the designation of the compliance officer and committee as specified in **§ 3.7** of the Provider Agreement.

9. Grievance System

A description of the CCN's Grievance System which includes a flow chart delineating the CCN's entire appeals process.

10. Financial Requirements

Proof of required capitalization and surplus requirements as specified in **§2.5** of the Provider Agreement.

11. Provider Compensation Arrangements

Physician Incentive Plans or Other Incentive Plans.

12. Drug-Free Workplace Policy

A copy of the CCN's drug-free workplace policy

13. Intent to Enter in to an MOU with the Office of Public Health

Letter of intent to enter into a Memorandum of Understanding with DHH Office of Public Health pursuant to meeting the the OPH Assistant Secretary to indentify common public health/CCN goals and actions to leverage and coordinate resources and programs to meet common goals of mutual benefit. To schedule the meeting, contact OPH at (225) 342-6188. See Appendix CC.

14. Additional Required Submissions

Any other document specified in the Provider Agreement or this ***Guide*** that is not listed above and subsequently deemed necessary by

DHH. (See Section 21 - Readiness Review of the ***Guide*** for additional required submissions during Step 2)

The Medicaid Coordinated Care Section (MCCS) will review the documents internally. MCCS will notify the CCN of any changes or re-submissions that must be made.

MCCS reserves the right to request additional documents as it deems appropriate.

STEP 3: Readiness Review - MMIS and Enrollment Broker Connectivity

Concurrent to Step 2, the CCN will coordinate with Medicaid Management Information System (MMIS) Section to establish connectivity with Medicaid's fiscal intermediary claims payment system and with the MCCS to establish connectivity with the Enrollment Broker. The CCN shall:

a. Provide proof of data transfer capabilities verified in writing by DHH and the CCN. Proof shall constitute the successful transfer of test files via EDI and meet DHH file format requirements as specified in the ***CCN-S Systems Companion Guide***.

b. Demonstrate the ability to pre-process claims submitted by providers to the CCN. The CCN has two (2) business days from the date of receipt to pre-process claims and then forward only clean claims to DHH's FI in the format (paper or electronic) in which they were received.

c. Work with DHH pertaining to any testing initiative as required by DHH and shall provide sufficient system access to allow testing of the CCN's system by DHH and/or its FI.

STEP 4: Readiness Review - On-Site Review

The Readiness Review on-site visit will be conducted after required submissions and documents have been approved by MCCS. The CCN will be reviewed against a set of nationally recognized standards that represent DHH's expectations for successful operation within the Louisiana Medicaid Program. MCCS will make a copy of the Readiness Review process available on Medicaid's website. The Review will be conducted at the CCN's Louisiana location which includes a desk review of the various policies. MCCS will coordinate with the CCN to schedule the on-site review and to communicate the Department's expectations. The primary focuses of the on-site review include the areas of clinical operations and information systems and reporting

and interviews with staff to evaluate knowledge, aptitude and readiness to implement program processes. Areas in either the written submissions and/or the on-site review process that require additional action on the part of the CCN are identified and appropriate corrective action will be recommended. Review of financial and claims systems and additional contract requirements will also be included.

STEP 5: Readiness Review – Determination of Adequacy of Network

Once Step 4 has been completed and approved by MCCS, MCCS will request and review the provider network submitted by the CCN to determine network adequacy.

a. Along with the provider network submission, the CCN will provide an attestation that all provider contracts are in compliance with the following requirements (See Appendix E – Attestation of Provider Network Submission):

   i. All **model** contracts and amendments have been approved by DHH;

   ii. All contracts have been properly signed;

   iii. All contracts include approved hold harmless language;

   iv. All contracts cover the services specified in the designated service are network submission; and

   v. All contracts (as appropriate) contain suitable documentation regarding hospital privileges and a listing of group practice members.

b. A listing (electronic file) of network provider/contractors with a hard copy in accordance with requirements set forth in in this ***Guide*** (See Appendix Y – CCN Network Provider and Contractor Listing Requirements). This submission must only include executed contracts. **(§ 4.13** of the Provider Agreement – *Adequacy of Providers)*

c. A geo-coded electronic file of all providers by service location specified in *b* above. The CCN shall also provide a hard copy of the GEO map of all network providers by provider type by parish to geographically demonstrate capacity.

STEP 6: Submission of Provider Agreement to CMS for Approval

Once Step 5 has been completed and DHH determines the CCN to be in compliance with all requirements, the Provider Agreement is submitted to CMS for approval.

STEP 7: Provider Agreement is finalized and Sent to CCN

Once DHH receives approval from CMS, DHH will forward the signed Provider Agreement to the CCN and notify Provider Enrollment Unit that the CCN is approved to obtain a Medicaid Provider Number.

STEP 8: Issuance of a Medicaid Coordinated Care Provider Number

Provider Enrollment notifies the CCN of their Medicaid provider number.

	Enrollment Process Activities*	CCN Timeline	MCCS Timeline
Step 1	Submission by CCN of Signed Provider Agreement and Required Documents to Formally Request Enrollment	No later than 4 months prior to "go live" date	Submit Notice of Approval or CAP within fourteen (14) days of receipt of required submissions.
Step 2	CCN submits Submissions Prior to On-Site Review	Within 30 days of Step 1 but not later than 4 months prior to "go live" date	Submit Notice of Approval or CAP within thirty (30) days of receipt of required submissions.
Step 3	Initiate/Begin Testing MMIS and Enrollment Broker Connectivity*	Initiate upon receipt of Step 2 Notice of Approval	Submit Notice of Approval or CAP within seven (7) days of established MMIS and Enrollment Broker connectivity.
Step 4	MCCS conducts On-site Review	Concurrent with Step 3.	Schedule ASAP after approval of Step 2; Allow 2-3 days to complete; Submit Notice of On-site Approval or CAP within 14 days of completed review.

	Enrollment Process Activities*	CCN Timeline	MCCS Timeline
Step 5	CCN submits documentation required for Network Adequacy determination	Within 7 days from receipt of On-site approval notice	Readiness Review is completed within fourteen (14) days from receipt of documentation.
Step 6	MCCS submits Provider Agreement for CMS approval		Up to forty-five (45) days.
Step 7	Final Provider Agreement Approval by DHH		ASAP – MCCS Forwards signed Agreement to CCN.
Step 8	Assignment of CCN Provider Number by DHH Provider Enrollment Unit		1 day. Issuance of Coordinated Care Provider Number to CCN.

*The potential time frames will be dependent upon whether the submissions/information provided by the potential CCN entity are complete and accurate and in compliance with the requirements set forth in the Provider Agreement and this ***Guide***. The time frames specified for DHH activity performance of tasks are DHH's best estimate and may be revised as deemed necessary. The time frames specified for CCN activities are firm.

DHH may provide information and guidance, illustrative direction, and technical assistance to assist the CCN during the CCN application process. This information is not meant to be exhaustive and neither constitutes legal or medical advice, nor does it replace any laws, rules, policies, or executed Provider Agreements. The technical assistance and guidance contained herein is for informational purposes only and the CCN's reliance upon this information does not guarantee a Provider Agreement with DHH. By providing this information, DHH does not waive any legal right or remedy to which it may be entitled including the right to pursue corrective actions, fines or other sanctions including, termination of provider agreements.

Sequence of Application Review

Below is the sequence of application review:

1. CCN submits required documents.
2. DHH conducts preliminary review to determine whether all required documents are included.
3. If initial deficiencies found:

- DHH notifies CCN via letter identifying deficiencies.
- CCN has ten (10) calendar days to submit corrected deficiencies.
- If deficiencies still exist, DHH suspends the application via letter to CCN.
- If deficiencies satisfactorily corrected, proceed to #4 below.

4. If no initial deficiencies (or initial deficiencies corrected timely):

   - DHH or its designee schedules Readiness Review (Steps 3 and 4 of CCN Enrollment Process above will be conducted concurrently)
   - DHH begins X12 and other data exchange testing with CCN as specified in the *DHH Systems Companion* ***Guide***.

5. DHH will issue an official letter listing any remaining deficiencies.

6. If remaining deficiencies exist:

   - CCN has five (5) calendar days to respond;
   - DHH has ten (10) calendar days to review additional material;
   - If deficiencies still exist, DHH suspends the application via letter to CCN; and
   - If deficiencies satisfactorily corrected, proceed to the next step.

   No remaining deficiencies. Proceed to #7 below.

7. If no deficiencies (or remaining deficiencies corrected timely), DHH or its designee proceeds with onsite review at Louisiana location.

8. DHH or its designee has fourteen (14) days to complete Readiness Review report and provide CCN notice of any deficiencies.

9. CCN submits corrective action if necessary.

10. If no deficiencies found on site visit, or when deficiencies are corrected, DHH signs the CCN Provider Agreement and submits to CMS for approval.

11. Provider Agreement becomes effective with the CCN receiving initial enrollment effective the date specified in the Provider Agreement.

Provider Network Adequacy Determination Process

Medicaid enrolled CCNs are responsible for providing enhanced primary care case management specified in the Provider Agreement in accordance with all State rules, regulations, policy statements, and provider manuals. The CCN shall enter into contracts with primary care providers (PCP) who will provide care management to members in exchange for payment by the CCN.

The CCN and its network providers/contractors shall ensure access to enhanced primary care case management and PCP care management services in accordance with the Provider Agreement and this ***Guide***.

Factors regarding access to primary care providers such as distance traveled, waiting time, length of time to obtain an appointment, and after-hours care must meet specified requirements in the Provider Agreement and this ***Guide***. The CCN shall ensure 24-hour-a-day, 7-days-a-week availability of information, referral, and treatment for emergency conditions. Additional Provider Network requirements are listed in this section of the ***Guide***.

Exceptions may be made, upon Department approval, if the travel distance for access to a PCP exceeds the mileage standards set forth in the Provider Agreement and/or the ***Guide***.

CCN's Approved Model Contracts Changes

The CCN shall submit all contract changes, that materially impact the terms and conditions of the contract, to DHH for approval prior to execution of any model contract modifications. The CCN shall electronically submit a redline version of the requested contract modifications or copy of the modifications made in an attachment (e.g., special provision exhibit/attachment) that have been incorporated into and with the model contract and which must contain the following information:

- All requested language changes and deviations from the approved model;
- Headers, completed reimbursement page, completed information of contract facility(ies) including locations, complete provider information including location(s), attachments or amendments, and the projected execution date of the contract;
- PCP care management services; and
- Footer information containing the original model contract approval number and date.

Once the redlined contract or attachment has been given tentative approval by DHH, the footer information will be changed to a tracking number provided by DHH. The CCN must submit a black-line copy of the tentatively approved redlined contract for final approval. Once the final approval has been given, the CCN and contractor may execute the contract.

Designated Service Area Provider Network Approval Process

The requirements outlined below shall be used in the review and approval of a CCN's provider network. Any changes (terminations/additions) to a CCN's network in any designated service area will be evaluated by DHH using the same criteria.

The CCN must submit its network listing during Step 5 of the CCN Enrollment Process for approval and prior to member enrollment in that designated service area. The CCN must follow the CCN Network Provider and Contractor Listing Spreadsheet Requirements (See Appendix Y), along with the CCN Model Attestation Form (See Appendix E) found in this

Guide. The CCN is responsible for ensuring that all providers are **enrolled** to participate in the Louisiana Medicaid Program.

The CCN shall only list currently enrolled Medicaid providers. Using the Contractor Listing Spreadsheet Requirements (Appendix Y), DHH or its designee will examine the listing for the inclusion and availability of primary care providers (PCPs).

1. The network PCP adequacy is evaluated based on the CCN's projected maximum member enrollment capacity for that designated service area, access standards (e.g. time, travel distance, capacity, etc.) and the network criteria.

2. If the submitted provider network is determined not to be adequate by the MCCS, MCCS will provide reasons and documentation for denial will be submitted to the Medicaid Deputy Director for final determination.

3. If the Medicaid Deputy Director determines that a network is not adequate, the CCN will be notified in writing that the network is not approved and the specific reasons for that decision.

4. If DHH determines that the CCN has demonstrated an adequate network, the network is approved, the effective date for enrollment is set, and the CCN is notified in writing. DHH will also notify the MMIS system to modify the "designated service area" indicator in the provider file to allow member enrollments to be processed. Also, the Enrollment Broker is informed of the addition of the approved CCN and their designated service areas.

5. DHH reserves the right to perform a CCN on-site review to review provider contracts, including any applicable approved amendments, and Hold Harmless Agreements. Should DHH exercise its right to review, contracts and Hold Harmless Agreements are reviewed to determine whether the language in the contracts has been previously approved by DHH and to ensure that **all** agreements are properly executed.

6. DHH does not require that the provider contract/hold harmless agreement be physically examined during the review process, if the provider contract/hold harmless agreement has been reviewed and approved within 60 days prior to the current examination.

LEFT BLANK INTENTIONALLY

SECTION 3 - CCN REQUIREMENTS

The CCN shall ensure the provision of enhanced primary care case management services including but not limited to service authorization, quality management, utilization management, chronic care management, and case management.

General Provisions:

The CCN shall:

- Ensure the provision of all enhanced primary care case management and PCP care management services specified in the Provider Agreement. Accessibility, including geographic access, appointments, and wait times shall be in accordance with the requirements in the Provider Agreement and this ***Guide***. These minimum requirements are not intended to release the CCN from the requirement to provide, refer and or coordinate medically necessary Medicaid covered services required for its members, whether specified or not.

- Ensure the provision of enhanced primary care case management directly or enter into written contracts with providers or organizations that shall provide such services to the members in exchange for payment by the CCN for such services .

- Ensure the provision of PCP care management through contracts with providers to provide such services to members in exchange for payment by the CCN as contractually specifiedNot execute contracts with providers who have been excluded from participation in any federally or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov and http://www.epls.gov and Health Integrity and Protection Data Bank at http://www.npdb-hipdb.hrsa.gov/index.html

- Ensure that CCN physicians maintain hospital admitting privileges or that they have arrangements with a physician who has hospital admitting privileges .

- Comply with the access standards when establishing and maintaining the provider network, and/or requesting expansion to other parishes or requesting enrollment level increases.

- Establish written policies and procedures for the selection and retention of providers. These policies and procedures shall not discriminate against particular providers that serve high risk populations or specialize in conditions that require costly treatment. The CCN's ability to maintain a provider network and not include any willing provider, is not considered discrimination.

- Give affected provider written notice if it declines to include individual or groups of individuals in its provider network.

- Maintain all contracts in accordance with the provisions specified in the Section 5 – *CONTRACT REQUIREMENTS* of the Provider Agreement and this ***Guide***.

- Not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:

    - Members health status, medical or behavioral health care, or treatment options, including any alternative treatment that may be self administered;

    - Information the member needs in order to decide among all relevant treatment options;

    - The risk, benefits, and consequences of treatment and non-treatment; or

    - The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

- Allow each member to freely choose their CCN PCP.

- Monitor provider compliance with applicable access requirements, including but not limited to, appointment and wait times, and take corrective action for failure to comply. The CCN shall conduct service area review of appointment availability and twenty-four (24) access and availability surveys annually. The survey results must be kept on file and be readily available for review by DHH upon request. Demonstrate sufficient accessibility and availability of enhanced primary care case management and PCP care management, by complying with all reporting requirements.

- Comply with the Office of Minority Health, Department of Health and Human Services' "Cultural and Linguistically Appropriate Services Guidelines" http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 and participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees.

- If a member requests a CCN provider who is located beyond access standards, and the CCN has an appropriate provider within the CCN who accepts new patients, it shall not be considered a violation of the access requirements for the CCN to grant the member's request. However, in such cases, DHH shall not be responsible for providing transportation for the member to access care from this selected provider, and the CCN shall notify the member in writing as to whether or not DHH will provide transportation to seek care from the requested provider.

Hours of Operation

The CCN shall adhere to the following hours of operation:

- Normal business hours which are Monday through Friday, 8 a.m. to 5 p.m., Central Time for general office based staffing.
- Be operational on all Department regularly scheduled business days. A listing of holidays may be found at:

  http://www.civilservice.la.gov/OtherInfo/StateEmployeesInfo/bene%20HOLIDAYS.asp
- Require providers to offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to non-Medicaid members.
- Provide access within the CCN to primary care providers that offer extended office hours (minimum of 2 hours) at least one day per week (after 5:00 pm) and on Saturdays [four (4) hours or longer].
- Ensure a toll-free number is available from 7 a.m. to 7 p.m. Central Time Monday through Friday for providers and members to access administrative components of the CCN's operations including, but not limited to, member services, requests for authorization, and for questions, concerns, complaints and request for PCP changes. 42 CFR §438.6(k)(1).

Provider Relations

The CCN must, at a minimum, provide a provider services function to promote the medical home concept and provide support and assistance to all providers serving Medicaid/CHIP members. This function must be available during normal business hours to address non-emergency provider issues.

The CCN shall assure each CCN provider is provided all rights outlined the Provider's Bill of Rights (see Appendix J).

The CCN shall provide for arrangements to handle emergent provider issues on a 24/7 basis.

The CCN shall provide ongoing provider training, respond to provider inquiries and provide general assistance to providers regarding program operations and requirements.

The CCN shall make regularly scheduled visits to provider sites, as well as *ad hoc* visits as circumstances dictate.

Network Provider Development and Management Plan

The CCN shall develop and maintain a Network Provider Development and Management Plan which describes how the CCN shall assure DHH that the provision of PCP care management services shall occur as specified in the Provider Agreement. A copy of the plan shall be available for Step 2 of the CCN Enrollment Process – Submission Prior to On-Site - available at Readiness Review.

The Network Provider Development and Management Plan shall include the CCN's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access to PCP care management services as specified in the Provider Agreement and this ***Guide***. The Network Provider Development and Management Plan shall demonstrate the ability to provide access to PCP care management servicesas defined in this ***Guide*** and shall include:

- Access to Primary Care Providers
    - Timely Access
    - Service Area

The CCN shall provide GEO mapping and coding of all network providers during the Readiness Review to geographically demonstrate capacity. The CCN shall provide updated GEO coding to DHH quarterly, or upon significant change as defined in the subsection "Network Changes" or upon request.

An evaluation of the initial Network Provider Development and Management Plan, including evaluation of the success of proposed interventions and any needed revisions, shall be submitted to DHH at the end of the first year of operations and annually thereafter.

Network Changes

The CCN shall submit a request for initial or expansion review, including submission of its provider network, to DHH when it has met the standards in this ***Guide***. DHH will not approve the network until all Provider Agreement requirements have been met.

The CCN shall provide written notice to DHH, no later than seven (7) business days prior to the effective date of any network provider contract termination that materially impacts the CCN's provider network, whether terminated by the CCN or the provider, and such notice shall include the reason(s) for the proposed action.

A network provider material change is defined as adecrease in the total of individual PCPs by more than five percent (5%) which impair or deny member's adequate access to a PCP.

The CCN shall have procedures to address changes in the CCN's provider network that negatively affect the ability of enrollees to access services, including access to a culturally diverse PCP network. Material changes in network composition that negatively impact enrollees' access to services may be grounds for termination of the Provider Agreement or sanctions as determined by DHH and in accordance with the Provider Agreement and this ***Guide***.

DHH may impose a sanction of up to twenty-five hundred dollars ($2,500) for each calendar day that there is a reduction in providers in the CCN's designated service area that impairs or denies member(s) adequate access, and for any day the CCN fails to implement an

approved corrective action plan. DHH will allow the CCN thirty (30) days from each phase in implementation date of the Coordinated Care Program to come into compliance with this requirement.

Record Retention

All records originated or prepared in connection with the CCN's performance of its obligations under the 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 the Provider Agreement.

LEFT BLANK INTENTIONALLY

SECTION 4 – ACCESS STANDARDS AND GUIDELINES

The CCN shall maintain and monitor a provider network that is supported by written formal contracts and is sufficient to provide PCP care management services to CCN members in accordance with the provisions of the Provider Agreement, ***CCN-S Policy and Procedure Guide*** and Medicaid rules and regulations. These services shall include, but not be limited to, referral to and coordination of medically necessary Medicaid covered services.

When designing the network of providers, the CCN shall comply with the following::

- Anticipated number of members;
- Expected utilization of services, taking into consideration the characteristics and health care needs of the members;
- The numbers of CCN providers who are not accepting new members; and
- The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members..

If a current Medicaid provider requests participation in a CCN, the CCN shall make a good faith effort to execute a contract. In the event an agreement cannot be reached and the provider does not participate in the CCN, the CCN has met this requirement, however, the CCN shall maintain documentation detailing efforts made.

Assurance of Adequate Access and Capacity

- **Access to Primary Care Providers (PCP)**

  The CCN shall ensure that each member has an identified PCP who is responsible for referral and coordination to both in- and out-of-network providers. Coordination shall include but not be limited to:

  - Referring patients to subspecialists and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available.

  - Communicate with other levels of care (primary care, specialty outpatient care, emergency and inpatient care) to coordinate, and follow up the care of individual patients.

  The CCN shall ensure that there are PCPs are willing and able to provide the level of care management to meet the needs of its members, including those with special needs and chronic conditions, with a sufficient number of PCPs accepting new members within the service area.

  The CCN may, at its discretion, allow vulnerable populations (for example persons with multiple disabilities, acute, or chronic conditions, as determined by the CCN) to select

their attending specialists as their PCP so long as the specialist is willing to perform responsibilities of a PCP and is a CCN provider.

DHH defines a full-time PCP as a provider that provides primary care services for a minimum of thirty-two (32) hours per week of practice time. A PCP shall be defined as family practice, general practice, pediatrics, OB/GYN, or internal medicine. The PCP to Medicaid member patient ratio (inclusive of all CCN members and CommunityCARE enrollees) shall not exceed the following unless approved by DHH:

- Physician – 1: up to 2,000
- Nurse practitioner (not linked to a physician group) – 1: up to 1,000
- Physician with physician extenders (Nurse Practitioner/Physician Assistant; and Certified Nurse Midwife for OB/GYNs only) may increase basic physician ratio of 1: up to 2,000 by 1,000 per extender. The maximum number of extenders shall not exceed two (2) extenders per physician.
- The CCN may request an exception to the PCP-to-patient ratio to DHH for approval.

The CCN shall enter into contracts with a sufficient number of PCPs to ensure adequate accessibility and sustainability for members in compliance with 42 CFR §438.206. The CCN's PCP care management responsibility shall, at a minimum, include:

- Establishing and maintaining hospital admitting privileges sufficient to meet the needs of all linked members, or entering into formal arrangements for management of inpatient hospital admissions of members;
- Maintaining continuity of each member's health care by serving as the member's PCP;
- Offering hours of operation that are no less than the hours of operating hours offered to commercial members or comparable to commercial health plans if the PCP does not provide health services to commercial members;
- Providing referrals for specialty care and other medically necessary services which the PCP does not provide, both in-network and out-of-network;
- Ensuring follow-up and documentation of all referrals;
- Maintaining a current and complete medical record for the member, including documentation of all services and referrals provided to the member, including but not limited to, services provided by the PCP, specialists, and providers of ancillary services.
- Adhering to the EPSDT periodicity schedule for members under age twenty-one (21);
- Following established procedures for coordination of in-network and out-of-network services for members; and
- Actively participating in and cooperating with all CCN quality initiatives and programs.

The CCN shall ensure member access to PCP services, that comply with time and distance standards, during extended office hours (minimum of 2 hours per week), earlier or later than traditional hours, at least one day of the week (Monday-Friday) ;**and** four (4) hours on the weekend.

Timely Access

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

- In office waiting time for scheduled appointments should not routinely exceed forty-five (45) minutes.
    - Providers may be delayed when they "work in" urgent cases, when a serious problem is found with a previous patient, or when a previous patient requires more services or education than was described at the time the appointment was scheduled. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than ninety (90) minutes, the patient shall be offered a new appointment.

  Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.
- Walk-in patients with urgent needs should be seen within twenty-four (24) hours.

The CCN shall monitor providers regularly to determine compliance with this Section; and take corrective action if there is a failure to comply.

Other Access Requirements

- **Direct Access to Women's Health Care**

  The CCN shall provide direct access to a health specialist(s) for women's routine and preventive health care services. This access shall be in addition to the member's PCP if that provider is not a women's health specialist. The CCN shall:

    - Notify and give each member, including adolescents, the opportunity to use their own PCP or utilize any family planning service provider for family planning services without requiring a referral or authorization; and
    - Maintain the confidentiality of family planning information and records for each individual member including those of minor patients.

- **Second Opinions**

  In accordance with 42 CFR §438.206(b)(3-5), if requested by a member or their representative, the CCN shall provide for a second opinion from a qualified health care professional within the CCN or refer the member outside the networkto a

Medicaid fee-for-service qualified health care professional is not available within the CCN.

- **Office of Public Health**

  The CCN shall make a good faith effort to execute a contract with the Office of Public Health (OPH) for the provision of personal health services offered within the parish health units (e.g. immunications, STD, family planning). In the event an agreement cannot be reached and the Office of Public Health does not participate in the CCN, the CCN shall maintain documentation details efforts which were made.

  The CCN will ccordinate its public health-related activities with the OPH. Coordination mechanisms and operational protocols for addressing public health issues will be negotiated with OPH and BHSF (Medicaid) and reflect Louisiana public health priorities. The coordination of activities related to public health will take the form of agreements among the parties which may include policy memos or separate memorandums of understanding signed by OPH, BHSF (Medicaid), and the CCN.

- **Coordination with Other Service Providers**

  The CCN shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid/CHIP eligibles. Such other services may include: Head Start programs; Early Intervention programs; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with consent of the enrollee).

Cultural Competency

The CCN shall require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and provide for interpreters in accordance with 42 CFR §438.206.

Patient-Centered Medical Home (PCMH)

- Patient-Centered Medical Home (PCMH) is a system 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, mental health programs, and home health agencies. DHH has expanded the (NCQA) definition of PCMH to incorporate primary care providers inclusive of physician-led and nurse-practitioner-led primary care practices. The CCN shall promote and facilitate the capacity of primary care practices to function as patient-centered medical homes by using systematic, patient-centered and coordinated care management processes; and to receive National Committee on Quality Assurance (NCQA) Physician Practice Connections®-Patient-Centered Medical Home (PPC®-PCMH) recognition.

- The CCN shall provide a PCMH Implementation Plan within ninety (90) days of phase-in implementation that identifies the methodology for promoting and facilitating PPC®-PCMH recognition. The implementation plan shall include, but not be limited to:

  - Payment methodology for payment to primary care practices for the specific purpose of supporting necessary costs to transform and sustain NCQA PPC®-PCMH recognition through enhanced payment or performance based incentives for achieving the necessary parameters;

  - Provision of technical support, to assist in their transformation to PPC®-PCMH (e.g., education, training, tools, and provision of data relevant to patient clinical care management);

  - Facilitation of specialty provider network access and coordination to support the PCMH; and

  - Facilitation of data interchange between PCMH practices, specialists, labs, pharmacies, and other providers.

- The CCN shall meet or exceed the following thresholds and timetables for primary care practices to achieve NCQA PPC®-PCMH recognition:

  - By the end of the first year of operations in the region:

    - 20% of practices shall be recognized NCQA Level 1

  - By the end of the second year of operation under the Provider Agreement:

    - 30% of practices shall be recognized NCQA Level 1
    - 10% of practices shall be recognized NCQA Level 2

  - By the end of the third year of operation under the Provider Agreement:

    - 10% of practices shall be recognized NCQA Level 1
    - 40% of practices shall be recognized NCQA Level 2
    - 10% of practices shall be recognized NCQA Level 3.

- The CCN shall submit an annual report indicating primary care practices that are NCQA PPC®-PCMH recognized and the levels of recognition. Nurse practitioner-led practices must meet NCQA PPC®-PCMH Level 1 recognition requirements and notify the CCN, via attestation and supporting documentation, of the level achieved. The CCN may include these practices, and identify in reporting, the number of these practices that have met NCQA PPC®-PCMH Level 1 requirements

The CCN shall participate in Patient-Centered Primary Care Collaborative activities.

Subsequent renewal of the Provider Agreement beyond the initial three-year period will require increased percentage of NCQA recognition to eighty per cent (80%) of practices.

LEFT BLANK INTENTIONALLY

SECTION 5 – MEMBER ENROLLMENT

Enrollment Populations

The CCN shall provide members with enhanced primary care case management and PCP care management services specified in the Provider Agreement and this ***Guide***.

Enrollment Process

General Provisions

DHH will contract with an Enrollment Broker that will be responsible for the CCN enrollment and disenrollment of all Medicaid/CHIPeligibles for whom enrollment is mandatory or voluntary. The Enrollment Broker shall be the primary contact for Medicaid/CHIP eligibles concerning CCN enrollment and shall assist the individual in becoming 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.

Enrollment Broker - Enrollment Responsibilities

- **Enrollment Counseling**
  - The Enrollment Broker will make choice counseling available to all eligible Medicaid/CHIP individuals to provide assistance in selecting and enrolling into a CCN. Enrollment Broker staff will be available by telephone as appropriate to assist and provide choice counseling to CCN- potential enrollees and enrollees. CCN potential enrollees and enrollees will be offered choice counseling as well as multilingual enrollment materials or materials in alternative formats, large print, and/or Braille when needed.
  - The Enrollment Broker's responsibilities subsequent to eligibility determination will include, but not be limited to, the following:
    - Educating the Medicaid/CHIP eligible about CCNs in general including, but not limited to, the requirement to enroll in a CCN, the manner in which services typically are accessed under CCNs, the role of the PCP, the responsibilities of the CCN member, and his/her right to file grievances and appeals; and the right of the member to choose a PCP within the CCN, subject to the capacity of the provider.
    - Educating the family about benefits and/or services available through CCNs.
    - Informing the family of available CCNs and outlining criteria that might be important when making a choice (e.g., presence or absence of the family's

existing health care provider in a CCN's network, federally qualified health center availability, any enhanced benefits).

- Identifying any sources of third party liability which were not identified by the eligibility case worker.

- Identifying any barriers to access to care for enrollees such as:

  i. Necessity for multi-lingual interpreter services, and

  ii. Special assistance needed for members with visual and/or hearing impairments and members with physical and/or mental disabilities.

- **Accessibility of Enrollment Process**

  The Enrollment Broker shall ensure that the enrollment process is accessible to eligible Medicaid/CHIP-potential enrollees and enrollees by mail, internet, and toll-free telephone.

- **Distribution of CCN's Enrollment Materials**

  The Enrollment Broker shall be responsible to distribute **all** enrollment materials to all eligible Medicaid/CHIP enrollees by mail and/or other suitable means.

- **Notification of Availability of CCNs to Medicaid/CHIP Eligibles**

  The Enrollment Broker will inform the Medicaid/CHIP eligible of all CCNs available in the enrollee's geographic area. This information shall be provided 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 eligible indicates priority health needs. To assist Medicaid/CHIP eligible 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, both by mail and toll-free telephone, paper provider directories including any addendums provided by the CCN upon request.

- **Selection of a CCN**

  The Enrollment Broker shall assist the Medicaid/CHIP eligible with the selection of a CCN that meets the individual's needs by explaining in a non-biased manner the criteria that may be considered when selecting a CCN. Medicaid/CHIP eligibles who CCN enrollment is mandatory or voluntary 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. An extension of the choice period may be requested by the individual for an additional fifteen (15) days, if the request is

made to the Enrollment Broker prior to the fifteenth (15th) day. All members of a family unit will be required to select the same CCN unless extenuating circumstances warrant a different CCN.

The CCN may provide orientation training on the benefits/services provided by the CCN to the Enrollment Broker staff. All orientation training shall be approved and monitored by DHH.

CCN - Enrollment Responsibilities

- **Policies and Procedures for Medicaid/CHIP Eligibles**

  In accordance with 42 CFR §438.10(b)(1), the Enrollment Broker and CCN shall provide all enrollment notices, informational materials, and instructional materials for enrollees and potential enrollees in a manner and format that is easily understood. All materials must be in compliance with DHH's Person First language policy (See Appendix S) and approved by DHH prior to distribution.

  The CCN shall have written policies and procedures for notifying new members of enrollment within ten (10) calendar days after receiving notification from the Enrollment Broker. This notification must be in writing and include a listing of primary care providers' names, locations, and office telephone numbers that the enrollee may choose as their primary care provider, if the enrollee did not choose a PCP upon selection of the CCN.

  The CCN shall submit to DHH for approval during Step 2 of the CCN Enrollment Process , Submission Required Prior to On-Site, a copy of the procedures to be used to contact CCN members for initial member education. These procedures shall adhere to the enrollment process and procedures outlined in this ***Guide*** and the post enrollment procedures required in the Provider Agreement.

  New Medicaid/CHIP eligibles will have the opportunity to select a PCP within the CCN that: 1) is enrolled in the Louisiana Medicaid Program; 2) entered into a contract with the CCN; and 3) that is within a reasonable commuting distance from their residence.

- **Acceptance of All Eligibles**

  The CCN shall enroll any mandatory or voluntary CCN eligible who selects it or is assigned to it regardless of the individual's age, sex, ethnicity, language needs, or health status. The only exception will be if the CCN has reached its capacity or has restricted itself to pediatric enrollees or adult enrollees.

- **Change in Status**

  The CCN shall agree to report in writing to DHH's Medicaid Customer Service Units (See www.makingMedicaidbetter.com) any changes in contact information or identified third party liability for families or individual members within five (5) business days of identification, including changes in mailing address, residential address if outside Louisiana, e-mail address, telephone number and insurance coverage.

- **New Member Orientation**

  The CCN shall have written policies and procedures for the following, but not limited to:

  - Orienting new members to its benefits and services;
  - Role of the PCP;
  - What to do during the transition period, (e.g. How to access services, continue medications, and obtain emergency or urgent medical services when transferring from FFS or CommunityCARE to CCN, or from one CCN to another);
  - How to utilize services;
  - What to do in an emergency or urgent medical situation; and
  - How to a file a grievance and appeal.

  The CCN may propose, for approval by DHH, alternative methods for orienting new members and must be prepared to demonstrate their efficacy.

- **Choice of Providers**

  The CCN shall allow each member to choose their providers to the extent possible and appropriate.

- **Assignment of Primary Care Provider**

  As part of the financial Medicaid and LaCHIP application process, applicants may be given the option to indicate their preferred choice of CCN and PCP. If the choice of CCN and PCP is not indicated on the new eligible file transmitted by DHH to the Enrollment Broker, the Enrollment Broker shall contact the eligible individual to request their choice of CCN and PCP. The Enrollment Broker shall encourage the continuation of any existing satisfactory provider/patient relationship with their current PCP who is in a CCN. The name of PCP requested

by a new enrollee will be included in the Member File from the Enrollment Broker to CCN.

Upon receiving notification by the DHH's Enrollment Broker of a Medicaid/CHIP eligible's selection or automatic assignment to the CCN or if the requested PCP is not available, the CCN shall contact the member within ten (10) business days of receiving the Member File from the Enrollment Broker to assist the member in making a selection of a PCP. The CCN shall inform the member that each family member has the right to choose his/her own PCP. The CCN may explain the advantages of selecting the same primary care provider for all family members, as appropriate. The CCN shall confirm the PCP selection information in a written notice to the member.

Members who do not proactively choose a PCP within ten (10) days of enrollment with a CCN will be auto-assigned to a PCP by the CCN. The PCP auto-assigned to the member should be located within geographic access standards to the member's home and/or best meets the needs of the member. The CCN member has the freedom to request a change of PCP within the CCN at any time with cause.

- En**rollment Updates**

  The CCN shall have written policies and procedures for receiving weekly updates of new members from the Enrollment Broker and incorporating them into its management information system.

- **Reconciliation**

  - Enrollment - The CCN is responsible to reconcile the membership list of new enrollments and disenrollments received from the Enrollment Broker against its internal records on a weekly basis. It is the CCN's responsibility to notify the Enrollment Broker of any discrepancies within twenty-four (24) hours of transmission of the CCN file information.

  - Payment - The CCN will be provided an electronic file from the Medicaid Fiscal Intermediary (FI) listing all members for which the CCN received a PMPM payment and the amount received. The CCN is responsible for reconciling this listing against its internal records within the time frame stated in the ***CCN-S Systems Companion Guide***. See Appendix X for payment schedule. It is the CCN's responsibility to notify the FI of any discrepancies as specified by DHH. Lack of compliance with reconciliation requirements will result in the withholding a portion of the PMPM payment or monetary penalties as defined in the Provider Agreement and this ***Guide***, until requirements are met.

- **Services for New Members**

  The CCN shall agree to make available enhanced primary care case management and PCP care management services to which a member is entitled immediately upon his or her effective date of enrollment, which, with the exception of newborns, will always be the 1st day of a month.

Transition of Existing CommunityCARE Enrollees

Current CommunityCARE enrollees will be given a 30-day open enrollment period to choose:

- a CCN, if more than one CCN exists in their parish of residence, or
- the CCN *or* CommunityCARE PCP if only one CCN exists in an urban parish, or
- If only one CCN exists in a rural parish, the Medicaid/CHIP eligible will be assigned to that CCN if there is capacity. If there is not capacity the eligible shall remain enrolled in the CommunityCARE program.

The Enrollment Broker shall provide information to the Medicaid/CHIP eligible and encourage an informed and active selection. Individuals that fail to choose a CCN within the specified timeframe shall be auto-assigned to a CCN by the Enrollment Broker to ensure that services shall continue uninterrupted.

New Medicaid/CHIP Eligibles

As part of the eligibility determination process, Medicaid/CHIP applicants may receive information and assistance with making informed choices about the CCNs in their parish of residence and the availability of choice counseling. Medicaid/CHIP eligibles shall have the opportunity to talk with an Enrollment Broker representative who shall provide additional information to assist in choosing the appropriate CCN. The Enrollment Broker shall provide information on the CCNs from which they may select. Each new Medicaid/CHIP eligible shall be given fifteen (15) calendar days from postmark date that an enrollment form is sent to them by the Enrollment Broker to select a CCN and PCP. Eligibles 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. Enrollees that fail to choose within this timeframe shall be auto-assigned to a CCN by the Enrollment Broker and the CCN shall be responsible to assist the member in selecting their PCP.

The enrollment process specified in the above paragraph is also applicable to those current Medicaid/CHIP eligibles that are identified as a CCN population group but are not a mandatory population group in CommunityCARE. This population will be given a 30 day open enrollment period to choose a CCN.

If a Medicaid/CHIP eligible is in a mandatory population group for both the CCN program and CommunityCARE the following will apply:

- If there are two or more CCNs in the parish in which the individual resides, they shall select one.

- If there is only one CCN in an urban parish where the individual resides and the individual inclusion in a CCN is mandatory and the individual also meets the eligibility requirements of CommunityCare Program, the individual will have a choice between the CCN and CommunityCARE. Individuals whose basis of eligibility is pregnancy, or whose enrollment in a CCN is voluntary, will have a choice between the CCN and Medicaid Fee-for-Service.

- If there is only one CCN in a rural parish where the individual resides, the Medicaid/CHIPindividual will be assigned to the CCN, if there is capacity. If there is not capacity within the CCN, the individual shall be enrolled in CommunityCARE. Individuals whose basis of eligibility is pregnancy or whose enrollment in a CCN is voluntary ,will have a choice between the CCN and Medicaid Fee-for-Service

- If the Medicaid/CHIP eligible does not request a transfer out of the CCN within 90 days from postmark date of the enrollment notification, they will be "locked-in" to the CCN for the next 9 months or until the next open enrollment, unless they are disenrolled for "*cause*".

- Medicaid/CHIP eligibles that fail to make a selection will be auto-assigned to a participating CCN in their area.

If a Medicaid/CHIP eligible is in a mandatory CCN population and a non-mandatory CommunityCARE population the following will apply:

- If there are two or more CCNs in the parish in which the individual resides, the individual shall select a CCN or be auto-assigned to one if a choice is not made.

- If there is only one CCN in an urban parish where the individual resides, the individual will have a choice between the CCN and FFS.

- If there is only one CCN in a rural parish where the individual resides, the Medicaid/CHIP eligible will be assigned to the CCN, if there is capacity. If there is not capacity within the CCN, the individual shall be enrolled in FFS.

- If the Medicaid/CHIP eligible does not request a transfer out of the CCN within 90 days from postmark date of enrollment notification, they will be "locked-in" to the CCN for the next 9 months or until the next open enrollment, unless they are disenrolled due to *cause.*

- Medicaid/CHIP eligibles that fail to make a selection will be auto-assigned to a participating CCN in their area.

If the Medicaid/CHIP eligible is in a voluntary population group, the following will apply:

- If there are two or more CCNs in the parish in which the individual resides, they may select one.
- If there are less than two CCNs in an urban parish where the individual resides, the individual will have a choice between the CCN and FFS.
- If there is only one CCN in a rural parish where the individual resides, the Medicaid/CHIP eligible will be assigned to the CCN, if there is capacity. If there is not capacity within the CCN, the individual shall be enrolled in FFS.
- Voluntary enrollees may request to transfer out of the CCN at any time to the Medicaid FFS Program and the change will be effective the first day of the following month.
- Voluntary Medicaid/CHIP potential enrollees that fail to make a selection will by default be auto-assigned to a participating CCN in their area.

Annual Open Enrollment

DHH, through its Enrollment Broker, will provide an opportunity for all CCN members to retain or select a new CCN annually during DHH's open enrollment period. Prior to the annual open enrollment period (end of October – end of December), each CCN member shall receive information and the offer of assistance with making informed choices about the CCNs in their area and the availability of choice counseling. The Enrollment Broker shall provide the individual with information on the CCNs from which they may select. Each Medicaid/CHIP enrollee shall be given sixty (60) calendar days to retain their existing CCN or select a new CCN.

If a Medicaid/CHIP member fails to select a new CCN during the annual open enrollment period they will remain with the CCN in which they are already a member.

Eligibility Period

Children under age 19 in Louisiana have twelve months continuous eligibility in both Medicaid and LaCHIP programs. Children do not lose eligibility prior to expiration of the twelve (12) month period unless they turn age 19 or move out of state with the intent to remain. For eligibles other than children, renewals are conducted every 12 months.

PCP Selection

The CCN is responsible to track linkages of all Medicaid/CHIP eligibles to a primary care provider in the CCN's network. The CCN is responsible to verify with the PCP, on a

quarterly basis, that the PCP has not exceeded their total allowable Medicaid linkages including linkages within the CCN, and linkages in other CCNs.

The CCN shall be responsible to report to DHH and/or its designee, the maximum number of members that can be linked to each PCP as well as the actual number linked to each PCP within the CCNon a quarterly basis in a format to be established by DHH.

Discrimination

The CCN shall accept potential enrollees in the order in which they are assigned without restriction, up to the enrollment capacity limits set under the Provider Agreement with DHH. The CCN shall not discriminate against enrollees on the basis of race, gender, color, national origin, age, health status or need for health care services, and shall not use any policy or practice that has the effect of discriminating on any such basis. The CCN shall be subject to administrative sanctions if it is determined by DHH the CCN has requested disenrollment for any of these reasons.

Automatic Assignment Methodology Process

- **Automatic Assignment to CCN**
  - Potential enrollees/enrollees that fail to select a CCN within the thirty (30) day window shall be automatically assigned to a CCN by the Enrollment Broker in accordance with DHH's approved algorithm/formula.
  - CCN automatic assignments shall take into consideration the following factors:
    - 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 PCP relationships linkage with a CommunityCARE PCP (CommunityCARE PCP at transition from CommunityCARE to CCN);
    - Quality Indicators (when available); and
    - Provider practice restrictions/limits.

  Neither the Prepaid Coordinated Care Network Model nor the Shared Savings Model will be given preference in making auto assignments.

If an entity is operating both a Prepaid and a Shared Savings Model within a service area, it will be treated as one entity for auto assignment purposes with assignment made equally between the two.

- **PCP Automatic Assignment by CCN**
  - The CCN is responsible to develop a PCP automatic assignment methodology in collaboration with DHH to assign an enrollee to a PCP when the enrollee:
    - Does not make a PCP selection after a voluntary selection of a CCN; or
    - Selects a PCP within the CCN that has reached their maximum physician/patient ratio; or
    - Selects a PCP within the CCN that has restrictions/limitations (e.g. pediatric only practice).

The final CCN and PCP automatic assignment methodology must be provided in Step 2 of the CCN Enrollment Process and shared with contracted providers. Approval must be obtained from the Department prior to member enrollment and made available to recipients.

Lock-In Period

Following their initial enrollment into a CCN, members have ninety (90) days from the postmark date of the Notice of Enrollment in which they may change CCNs for any reason. After the initial ninety (90) day period, Medicaid/CHIP enrollees/members shall be locked into a CCN for nine (9) additional months from the effective date of enrollment or until the next annual open enrollment period, unless disenrolled under one of the conditions described in the *SECTION 6 - DISENROLLMENT* of this ***Guide***.

Enrollment Updates

The Enrollment Broker shall make available to the CCN daily via electronic media, updates on members newly enrolled into the CCN in the format specified in the ***CCN-S Systems Companion Guide.*** The CCN shall have written policies and procedures for receiving these updates, incorporating them into its management information system and ensuring this information is available to their providers. Policies and procedures shall be available for review at the Readiness Review.

The Enrollment Broker shall make available to DHH a listing of current CCN members, via electronic media on a monthly basis.

Reenrollment

In instances of a temporary loss of eligibility, which is defined under 42 CFR §438.56 as up to two (2) months, members shall be re-enrolled in the same CCN they were enrolled in prior to the temporary loss of eligibility, if the loss of eligibility causes the enrollee to miss the annual open enrollment period.

LEFT BLANK INTENTIONALLY

SECTION 6 - DISENROLLMENT

Involuntary Disenrollment Request by CCN for Cause

The following requirements for requests by the CCN are applicable for both mandatory and voluntary enrollees.

The CCN shall submit requests for involuntary disenrollment of a member that includes, at a minimum, the member's name, ID number, and detailed reasons for requesting the disenrollment utilizing the CCN Initiated Disenrollment Request to the Enrollment Broker (See Appendix P). The CCN shall not request disenrollment for reasons other than those stated in the Provider Agreement and this ***Guide***. (See Appendix I – Guidelines for Involuntary Member Disenrollment)

The following are acceptable reasons for which the CCN may request involuntary disenrollment of a member:

- A member's fraudulent use of the CCN's ID card. In such cases the CCN shall report the event to the Medicaid Program Integrity Section; and
- 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.

The CCN shall promptly submit such disenrollment requests to the Enrollment Broker. The CCN shall not 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. 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 are subject to the sole discretion of DHH or its designee (Enrollment Broker). All decisions are final and not subject to dispute resolution process by the CCN.

Department approved disenrollment requests 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 disenrollment, the reason for the request, and an explanation that the CCN is requesting that the member be disenrolled in the month following member notification, or earlier if necessary. Until the enrollee is disenrolled by the Enrollment Broker, the CCN shall be responsible for the provision of services to that member.

Request by the Member

Voluntary Enrollee - A member who is a voluntary enrollee may request disenrollment from a CCN with or without cause at any time.

Mandatory Enrollee - A member who is a mandatory enrollee may request disenrollment from a CCN as follows:

- For cause, at any time.
- Without cause for the following reasons:
    - During the ninety (90) days following the date of the member's initial enrollment with the CCN or the date DHH sends the member notice of the enrollment;
    - 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/CHIP 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).

Procedures

If a member requests disenrollment, he or she (or their designated representative) shall submit an oral or written request to the Enrollment Broker.

Oral requests to disenroll shall be confirmed by the Enrollment Broker orally with written documentation, or in writing to the requestor.

Disenrollment for Cause

A member in a CCN who is a mandatory enrollee and subject to the "lock-in" period may initiate disenrollment or transfer after the first ninety (90) days of enrollment for **cause only**. See **§6.7.2** of the Provider Agreement.

Departmental Action on Request

For a disenrollment request received directly from the member or referred by the CCN, the Enrollment Broker shall take action to approve or disapprove the request based on the following:

- Reasons cited in the request;
- Information provided by the CCN at DHH's request; or
- Any of the reasons specified in the "Disenrollment for Cause" in this ***Guide*** and/or the Provider Agreement.

Action of Disenrollment Request

If the CCN requests a member's disenrollment or receives a member's disenrollment request, the CCN shall forward the request to the Enrollment Broker in writing, via secure e-mail to an address, facsimile, or formal correspondence by mail or delivery specified by the Enrollment Broker.

If the disenrollment request is approved, the Enrollment Broker shall notify the member in writing of the action taken by the Department and give the member the opportunity to choose another CCN or file a request for a state fair hearing. In all cases the CCN shall continue to coordinate and provide care until the member has been disenrolled from the CCN.

Timeframe for Disenrollments

The effective date of disenrollment shall be no later than the first day of the second month following the calendar month the request for disenrollment is filed.

If DHH or its designee fails to make a disenrollment determination by the first day of the second month following the month in which the request for disenrollment is filed, the disenrollment is considered approved.

DHH, the CCN, and the Enrollment Broker shall reconcile enrollment/disenrollment issues at the end of each month utilizing an agreed upon procedure. (See ***CCN-S Systems Companion Guide***)

LEFT BLANK INTENTIONALLY

SECTION 7 - OTHER ENROLLMENT AND DISENROLLMENT REQUIREMENTS

Notifications

The Enrollment Broker shall provide marketing materials to each Medicaid/CHIP potential enrollee:

- At the time the potential enrollee first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program;
- Within a timeframe that enables the potential enrollee to use the information in choosing among CCNs, or if applicable, CommunityCARE and FFS;
- That includes the following:
  - General information about:
    - The basic features of CCNs;
    - Which populations are excluded from enrollment, subject to mandatory enrollment, or enrolled voluntarily in the program with option to withdraw ; and
    - CCN responsibilities for coordination of enrollee care.
  - Information specific to each CCN program operating in potential enrollee's service area. A summary of the following information is sufficient, but the state shall provide more detailed information upon request:
    - Benefits and services covered;
    - Cost sharing, if any; and
    - Service area.
  - Names, locations, telephone numbers of, and non-English language(s) spoken by current CCN providers, and including identification of CCN providers that are not accepting new patients. For CCNs, this includes, at a minimum, information on primary care providers, specialists, and hospitals;

- Benefits that are available under the state plan but are not covered under the Provider Agreement (*e.g.* dental, specialized behavioral health and pharmacy), including:
  - How and where the enrollee may obtain those benefits;
  - Any cost sharing; and
  - How transportation is provided.

- General information for all enrollees of CCNs. Information shall be furnished to the Medicaid/CHIP enrollee as follows:

  - DHH shall notify all enrollees of their disenrollment rights, at a minimum, annually and no less than 60 (sixty) days before the start of each enrollment period.

The Enrollment Broker shall provide members and/or their representatives with written notice of disenrollment rights at least sixty (60) days before the start of each annual open enrollment period.

The Enrollment Broker shall inform members of their right to a state fair hearing when dissatisfied with DHH's decision to deny the disenrollment request.

Transition

- **Between CCNs**

  The CCN shall develop and maintain effective continuity of care activities which ensure a continuum of care approach to providing health care services to CCN members. The CCN shall develop procedures for the smooth transition of members from one CCN to another. These procedures shall include, but are not to be limited to, coordination to services prior to assignment of the PCP, receipt of medical records, continuation of medications and prenatal services in accordance with **§§ 4.3 –** *Case Coordination, Continuity of Care and Care Transition* and **4.5 -** *Case Management* of the Provider Agreement.

  It may be necessary to transfer a member between CCNs for a variety of reasons, including changes during open enrollment, disenrollment or ordered as part of an appeals resolution. The CCN shall have written policies and procedures for the continuation and/or coordination of medical services and the transfer of relevant patient information, including medical records and other pertinent materials when a member changes CCNs. These policies and procedures shall be available at the Readiness Review and upon request by DHH.

- **Changing PCPs**

  The CCN shall develop written policies and procedures that allow members to change PCPs within the CCN, at any time, with cause. These policies and procedures shall be submitted during Step 2 of the CCN enrollment process and upon request by DHH. The CCN shall inform the members of the process for initiating these changes and obtaining medically necessary services in the interim.

  When it has been determined that a PCP is non-compliant with provider standards (i.e. quality of care) and is terminated from the CCN, or when a PCP change is ordered as part of the resolution to a grievance proceeding, the CCN shall have written policies and procedures for allowing members to select a new PCP, including auto-assignment, and provide information on options for selecting a new PCP. The CCN shall allow members to select another PCP within ten (10) business days of the postmark date of the termination of PCP notice to members and provide information on options for selecting a new PCP. The CCN shall have policies for accessing emergency/urgent care during this transition period.

  The CCN shall notify the Enrollment Broker of a PCP's termination by close of business the next business day.

Reporting

The CCN shall track all disenrollments by reason and date of decision and report to DHH or its designee on a quarterly basis in the format specified by DHH. (See Appendix N – CCN Disenrollment Report)

LEFT BLANK INTENTIONALLY

SECTION 8 – ENHANCED PRIMARY CARE CASE MANAGEMENT SERVICES

General Provisions

The CCN shall possess the expertise and resources to ensure the delivery of enhanced primary care case management services. The CCN shall be required to provide care management in addition to service authorization, refer, coordinate, and/or provide assistance in scheduling the services listed below. Service authorization requirements regarding service limits, with the exception of physician visits, shall be consistent with the standards as defined in the Title XIX Louisiana State Medicaid Plan and the ***CCN-S Policy and Procedure Guide.*** The CCN may choose to provide and/or authorize physician services over and above those specified in the State Plan when it is cost effective to do so.

The CCN may place appropriate limits on a service on the basis of criteria applied under the State Plan, such a medical necessity or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. The CCN shall provide the criteria utilized to DHH for written approval during Step 2 of the CCN enrollment process and annually, thereafter.

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. The following is a list (not all inclusive) of Medicaid State Plan services:

- Inpatient Hospital Services
- Outpatient Services
- Ancillary Medical Services
- Transplant-Related Services
- EPSDT/Well Child Visits
- Durable Medical Equipment
- Home Health Services
- Family Planning Services
- Basic Behavioral Health Services
- School-Based Health Clinic Services (with the exception of IEP services)
- Physician Services
- Chiropractic Services
- Therapy Services (physical, occupational, and speech therapies)

The CCN will be responsible to coordinate those services that by statute must be provided and are medically necessary. All claims will be paid FFS through the State's MMIS system. The CCN shall not implement hard limits/caps for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services

The CCN will not be responsible to authorize but shall provide any required referrals and coordination for carved out services. See Carved Out Services below.

The CCN shall operate consistent with all applicable Medicaid Provider Manuals and publications for minimal coverage and guidelines. If new services are added to the Louisiana Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the CCN shall implement the changes consistent with Department direction. The table in Appendix B - Table of Louisiana Medicaid State Plan Services provides a general overview of the Louisiana Medicaid Program's services, which are identified as either federally mandated or state legislatively approved optional services.

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, psychiatrist, psychologist, licensed clinical social worker, or licensed professional counselor either in 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.

For the purposes of the CCN program, behavioral health services shall be divided into two levels:

- Basic Services – 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. Basic behavioral health services may further be defined as are those provided in the member's PCP or medical office by the member's (non-specialist) physician (i.e., DO, MD, APRN) as part of routine physician evaluation and management activities (e.g., CPT codes 99201 through 99204), and all services provided at FQHCs/RHCs.). The CCN shall be required to work with PCPs to implement screening tools for basic behavioral health, such as the Patient Health Questionnaire, (PHQ-9), and the Pediatric Symptom Checklist (PSC, Y-PHC), which are subject to approval by Department. The CCN is financially responsible for the provision of these services; and

- Specialized Services - Specialized behavioral health services shall include, but are not limited to, services provided by a psychiatrist, psychologist, mental health rehabilitation provider, Community Mental Health Center (CMHC), and inpatient care to those members with a primary diagnosis of mental illness. These services shall be paid on a fee-for-service basis by DHH within the limitations and durations as set forth in the Medicaid State Plan.

Criteria for screening protocols and determining whether an individual meets the criteria for specialized behavioral health services shall be determined by DHH and is based on factors relating to age, diagnosis, disability (acuity) and duration of the mental health

illness/condition.

- **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. Basic behavioral health services/benefits shall include, but may not be limited to:

  - Screening, Prevention and Referral:

    - Screening, prevention, early intervention and referral services including screening services as defined in the EPSDT benefit (the EPSDT benefit guarantees coverage of "screening services" which must, at a minimum, include "a comprehensive health and developmental history – including assessment of both physical and mental health. Section 1905(r)(1)(B)(i) of the Social Security Act, 42 U.S.C. §1396d(r)(1)(B)(i));

    - Behavioral health services provided in the member's PCP or medical office as described under the "Basic Services" section above(e.g., DO, MD);

    - Outpatient non-psychiatric hospital services, based on medical necessity; and

    - Those behavioral health services for individuals whose need for such services is secondary to a primary medical condition in any given episode of care.

<u>Carved-Out Services</u>

Carved out services are those services which members may obtain under the Louisiana State Plan, and for which the CCN is not responsible to perform service authorization. However, the CCN is responsible to provide all required referrals and assist in the coordination of scheduling such services. Carved-out services include:

- Services provided through DHH's Early Steps Program;
- Dental;
- Hospice
- ICF/DD Services;
- 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 (these services are NOT provided by OPH-certified school-based health clinics);
- All Home and Community Based Waiver Services;
- Non-emergency and emergency transportation;
- Specialized Behavioral Health; and
- Targeted Case Management Services including Nurse Family Partnership.

Federally Qualified Health Centers (FQHCs)

The CCN shall provide members with access to services provided through a FQHC whether or not the FQHC has a contract with the CCN, if:

- the member resides in the service area in which the FQHC is located, and
- the member requests such services.

The CCN shall inform members of this right in their member handbooks.

If a CCN does not include a FQHC in their provider network and a FQHC exists in their designated service area, the CCN shall allow members to receive medically necessary services to treat an emergency medical condition from the out-of-network FQHCs (See §4.18 of the Provider Agreement).

The CCN shall have written procedures for promptly transferring medical information needed for coordinating care with a FQHC. CCNs shall expect a sharing of information and data and appropriate CCN referrals from non-network FQHCs.

The CCN shall have written procedures for promptly transferring medical information to a FQHC needed for coordinating care with a FQHC. CCNs shall expect a sharing of information and data and appropriate CCN referrals from non-network FQHCs.

Preventative and Safety Educational Programs/Activities

The CCN may provide healthy lifestyle educational programs/activities for the whole familywhich may include, for example, a discount to a local fitness facility, web access to a healthy cooking website, weight management program participation and/or a smoking cessation program. The CCN shall obtain approval from DHH prior to implementation of any such program.

Prohibited or Excluded Services under the Louisiana Medicaid Program

- Elective abortions and related services,
- Experimental/investigational drugs, procedures or equipment,
- Elective cosmetic surgery, and

- Services for treatment of infertility.

Women's Health Services

The CCN shall assure direct access by female members to an OB/GYN within the provider's network for routine OB/GYN services regardless of whether the PCP (general practitioner, family practitioner or internist) provides such services. Routine gynecological care shall mean a minimum of two routine annual visits, provided that the second visit shall be permitted based upon medical need only, and follow-up treatment provided within sixty (60) days following either visit if related to a condition diagnosed or treated during the visits, and any care related to a pregnancy.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) mandates **that all medically necessary services** listed in Section 1905(a) of the Social Security Act be covered under Medicaid for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program provided for Medicaid eligible individuals under the age of 21. (CFR 42, Subpart B §441.50– Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] of Individuals under Age 21) The CCN is responsible to provide **all medically necessary services whether specified in the core benefits and services and Louisiana Medicaid State Plan or not**, except those services (carved out/excluded/ prohibited services) that have been identified in this ***Guide***.

In Louisiana the screening component of this program in fee-for-service Medicaid is known as Louisiana KIDMED. The CCN is required to fulfill the medical, vision, and hearing screening components and immunizations as specified in the periodicity charts in DHH's KIDMED Manual.

The CCN shall accurately report, via submission of claims to DHH, all EPSDT and well-child services, blood lead screenings, and access to preventive services as required for DHH to comply with federally mandated CMS 416 reporting requirements.

Care Management

Care management is defined as the overall system of medical management encompassing Utilization Management, Case Management, Care Coordination, Continuity of Care and 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.

- **Referrals**

  The CCN shall submit specialty health care services referral policies and procedures for review and approval during Step 2 of the CCN Enrollment

Process, Submissions Required Prior to the On-Site Readiness Review, annually thereafter, and subsequent to any revisions. Referral policies and procedures shall include processes to ensure monitoring and documentation of specialty health care services and follow up are included in the PCP's member medical record. The CCN may request the assistance of DHH for the referral to the appropriate services setting. for carved out services. Referral policies and procedures shall include, at a minimum, the following elements:

- When a referral from the member's PCP is required;
- Process for member referral to an out-of-network provider when there is no provider within the CCN's provider network who has the appropriate training or expertise to meet the particular health needs of the member;
- Process for providing a standing referral when a member with a condition requires on-going care from a specialist;
- Process for referral to specialty care for a member with a life-threatening condition or disease who requires specialized medical care over a prolonged period of time;
- Process for member referral for case management;
- Process for member referral for chronic care management;

CCN referral policies must prohibit providers from making referrals for designated health services to health care entities with which the provider or a member of the provider's family has a financial relationship.

There must be written evidence of the communication of the patient results/information from the specialty healthcare provider in the PCP's patient record.

DHH strongly encourages the CCN to develop electronic, web-based referral processes and systems. In the event a referral is made via the telephone, the CCN shall ensure that referral data, including the final decision, is maintained in a data file that can be accessed electronically by the CCN, the provider and DHH.

- **Care Coordination, Continuity of Care, and Care Transition**

The CCN shall be responsible for the coordination and continuity of care of healthcare services for all members consistent with 42 CFR §438.208

- The CCN shall implement Department approved Care Coordination and Continuity of Care policies and procedures that meet or exceed the following requirements:

  - Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs;
  - Coordinate care between PCPs and specialists;
  - Coordinate care for out-of-network services, including specialty care services;
  - Coordinate CCN provided services with services the member may receive from other health care providers;
  - Share with other health care entities serving the member with special health care needs the results and identification and assessment of that member's needs to prevent duplication of those activities;
  - Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 subparts A and E, to the extent applicable;
  - Maintain and operate a formalized hospital and/or institutional discharge planning program;
  - Coordinate with hospital and/or institutional discharge planning that includes post-discharge care as appropriate;
  - Identify members using emergency department services inappropriately and assist in scheduling follow-up care with PCP and/or appropriate specialists;
  - Document authorized referrals in its utilization management system; and
  - Provide active assistance to members receiving treatment for chronic and acute medical conditions or behavioral health conditions to transition to another provider when their current provider has terminated participation with the CCN. The CCN shall provide continuation of such services for up to ninety (90) calendar days or until the member is reasonably transferred without interruption of care, whichever is less;

- **Continuity of Care for Pregnant Women**:

  - In the event a Medicaid/CHIP eligible entering the CCN is receiving medically necessary covered services in addition to, or other than, prenatal services (see below for new enrollees receiving only prenatal services) the day before CCN enrollment, the CCN shall provide continuation/coordination of such services up to ninety (90) calendar days or until the member may be reasonably transferred without disruption, whichever is less. The CCN may require prior authorization for continuation of the services beyond thirty (30) calendar days, however the CCN is prohibited from denying authorization solely on the basis that the provider is non-contract provider.

  - In the event a Medicaid/CHIP eligible entering the CCN is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before CCN enrollment, the CCN shall be responsible for the continuation/coordination of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider until such time as the CCN can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member's health.

  - In the event a Medicaid/CHIP eligible entering the CCN is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services the day before enrollment, the CCN shall be responsible for coordinating continued access to the prenatal care provider through the postpartum period.

- **Continuity for Behavioral Health Care**:

  - The PCP shall provide basic behavioral health services (as described in *this section)* and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.

  - In order to ensure continuity and coordination of care for members who appear to need specialized behavioral health

services or who may require inpatient/outpatient behavioral health services, the CCN shall be responsible for referring to the fee-for-service system for services.

- In any instance when the member presents to the network provider, including calling the CCN's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the CCN shall instruct the member to seek help from the nearest emergency medical provider. The CCN shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.

- The CCN shall comply with all post stabilization care service requirements found at 42 CFR §422.113.

- It is the expectation that there is documentation in the member's medical record that attempts are made to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's behavioral health provider.

- The network shall provide procedures and criteria for making referrals and coordinating care with behavioral health providers and agencies that will promote continuity, as well as, cost-effectiveness of care.

- These procedures must address members with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple provides, facilities and agencies and require complex coordination of benefits and services.

- The CCN shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures.

o **Continuity for Durable Medical Equipment, Prosthetics, Orthotics and Certain Supplies**:

- In the event a Medicaid/CHIP member entering the CCN is receiving Medicaid covered durable medical equipment, prosthetics, orthotics, and certain supplies (DMEPOS) services the day before CCN enrollment, whether such services were

provided by another CCN or Medicaid fee-for-service, the CCN shall be responsible for the continuation/coordination of these services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The CCN shall provide continuation of such services for up to thirty (30) calendar days or until the member may be reasonably transferred (within timeframe specified in this ***Guide***) without disruption, whichever is less. The CCN must also honor any prior authorization for DMEPOS issued while the member was enrolled in another CCN or the Medicaid fee-for-service program for a period of thirty (30) calendar days after the member's enrollment in the CCN.

- **Care Transition**

  - The CCN shall provide active assistance to members when transitioning to another provider (CCN, CommunityCARE or FFS programs).

  - The receiving CCN shall be responsible for the provision of medically necessary services covered under the Provider Agreement that are required for the member during the transition period (i.e. prenatal care, acute care, etc.). The transition period shall not exceed thirty (30) calendar days from the effective date of the member's enrollment in the receiving CCN. During this transition period, the receiving CCN shall be responsible for, but not limited to, notification ***to th***e new PCP of member's selection, initiation of the request of transfer for the member's medical files, arrangement of medically necessary services (if applicable) and all other requirements for new members.

  - If a member is to be transferred between CCNs but is hospitalized at the time, the transfer shall be effective for the date of enrollment into the receiving CCN. However, the relinquishing CCN shall notify the receiving CCN of the member's hospitalization status within five (5) business days.

  - Upon notification of the member's transfer, the receiving CCN shall request copies of the member's medical record, unless the member has arranged for the transfer. The previous provider shall transfer a copy of the member's complete medical record and allow the receiving CCN access (immediately upon

request) to all medical information necessary for the care of that member. Transfer of records shall not interfere or cause delay in the provision of services to the member. The cost of reproducing and forwarding medical records to the receiving CCN shall be the responsibility of the relinquishing CCN. A copy of the member's medical record and supporting documentation shall be forwarded by the relinquishing CCN's PCP within ten (10) business days of the receiving CCN's PCP's request.

- **Utilization Management**

The CCN shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) Program that incorporates Utilization Review including Service Authorization. The CCN shall submit UM policies and procedures to DHH for written approval during the Readiness Review, annually thereafter, and subsequent to any revisions.

The UM Program policies and procedures shall include medical management criteria and practice guidelines that are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; consider the needs of the members; are adopted in consultation with contracting health care professionals; and are reviewed and updated as appropriate. The UM Program medical management criteria and practice guidelines shall be reviewed annually and updated periodically as appropriate. The CCN must identify the source of the medical management criteria used for the review of service authorization requests. As such, the vendor must be identified if the criteria was purchased; the association or society must be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society; the guideline source must be identified if the criteria are based on national best practice guidelines; and the individuals who will make medical necessity determinations must be identified if the criteria is based on the medical training, qualifications, and experience of the CCN medical director or other qualified and trained professionals.

UM Program medical management criteria and practice guidelines shall be disseminated to all affected providers, members, and potential members upon request.

The CCN shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines. The CCN shall use DHH's medical necessity definition for medical necessity determinations. The CCN must identify the qualification of staff who will determine medical necessity. Determinations of medical necessity

must be made by qualified and trained practitioners in accordance with state and federal regulations.

The CCN shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.

The CCN shall provide a mechanism to reduce inappropriate and duplicative use of health care services. Services shall be sufficient in an amount, duration, and scope to reasonably to be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The CCN shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. The CCN may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.

The CCN shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.

The CCN shall report fraud and abuse information identified through the UM program to DHH's Program Integrity Unit in accordance with 42 CFR §455.1(a)(1).

The UM program shall integrate with other functional units of the CCN as appropriate and support the Quality Assessment and Performance Improvement (QAPI) Program (refer to the Quality Management subsection for details regarding the QAPI Program).

- The CCM shall form a UM Committee to provide utilization review and monitoring of UM activities of both the CCN and its providers and is directed by the CCN Medical Director. The UM Committee shall convene no less than quarterly and shall submit meeting minutes to DHH within five (5) business days of each meeting. Committee responsibilities include:

    - Monitoring providers' requests for rendering healthcare services to its members;

- Monitoring the medical appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling;
- Reviewing the effectiveness of the utilization review process and making changes to the process as needed;
- Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;
- Monitoring consistent application of "medical necessity" criteria;
- Application of clinical practice guidelines;
- Monitoring over- and under-utilization;
- Review of outliers, and
- Medical Record Reviews - reviews of member medical records shall be conducted to ensure that PCPs provide high quality health care that is documented according to established standards.

o The CCN shall maintain a written strategy for conducting medical record reviews, reporting results and the corrective action process. The strategy shall be provided during Step 2 of the CCN Enrollment Process, Submission of Documents Prior to On-Site Readiness Review, and annually thereafter. The strategy shall include, at a minimum, the following:

- Designated staff to perform this duty;
- The method of case selection;
- The anticipated number of reviews by practice site;
- The tool the CCN shall use to review each site; and
- How the CCN shall link the information compiled during the review to other CCN functions (e.g. QI, peer review, etc.)

- The standards, which shall include all medical record documentation requirements addressed in the Provider Agreement, shall be distributed to all providers.

- The CCN shall conduct reviews at all PCP sites with fifty (50) or more linked members and practice sites which include both individual offices and large group facilities. The CCN shall review each site at least one (1) time during each two (2) year period.

- The CCN shall review a reasonable number of records at each site to determine compliance. Five (5) to ten (10) records per site is a generally accepted target, though additional reviews shall be completed for large group practices or when additional data is necessary in specific instances.

- The CCN shall report the results of all medical record reviews to DHH upon request.

- **Service Authorization**

  Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post authorization. The CCN UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR §438.210 and state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following:

  - Written policies and procedures for processing requests for initial and continuing authorizations of services;

  - Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate; and

  - 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.

  - The CCN shall provide a mechanism in which a member may submit, whether oral 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.

- The CCN's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and non-participating providers.

- The CCN's service authorization system shall have capacity to electronically store and report all service authorization requests, decisions made by the CCN regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.

- **Timing of Service Authorization Decisions**

  i. Standard Service Authorization

     For a standard authorization decision, the CCN shall provide notice as expeditiously as the member's health condition requires, but no more than fourteen (14) calendar days following receipt of the request for service. An extension may be granted for an **additional** fourteen (14) calendar days if the member or the provider requests an extension, **or** if the CCN justifies to DHH a need for additional information and the extension is in the member's best interest.

  ii. Expedited Service Authorization

     In the event a provider indicates, or the CCN determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CCN shall make an expedited authorization determination and provide notice within three (3) business days. The CCN may extend the three (3) business days time period by up to fourteen (14) calendar days if the member or if the CCN justifies to DHH a need for additional information and how the extension is in the member's best interest.

  iii. Post Authorization

Decisions for authorization involving health care services that have been delivered shall be made within thirty (30) calendar days of receipt of the necessary information.

- **Notice of Action**

The CCN shall notify the member, in writing using language that is easily understood, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in**§9–** G*rievance and State Fair Hearing* in the Provider Agreement. The notice of action to members shall be consistent with requirements in 42 CFR §438.10(c) and (d) and**§9.6**– *Notice of Action* in the Provider Agreement.

The CCN shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested.

- **Medical History Information**

The CCN is responsible for eliciting pertinent medical record information from the treating health care provider(s), as needed and/or as requested by DHH, for purposes of making medical necessity determinations. The CCN shall take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe. Providers who do not provide requested medical information for purposes of making medical necessity determinations, for a particular item or service, shall not be entitled to payment for the provision of such item or service. Should a provider fail or refuse to respond to the CCN's request for medical record information, at the CCN's discretion or directive by DHH, the CCN shall, at a minimum, impose financial penalties against the provider as appropriate.

- **Exceptions to Service Authorizations and/or Referrals Requirements**

The CCN shall not require service authorization for emergency services or post-stabilization services as described in this Section whether provided by an in-network or out-of-network provider.

The CCN shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.

The CCN shall not require service authorization or referral for EPSDT screening services.

The CCN shall not require a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the CCN for routine and preventive women's healthcare services and prenatal care.

The CCN shall not require a PCP referral for access to specialized behavioral health services.

The CCN shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the CCN, regardless of whether such services are provided by an in-network or out-of-network provider, however, the CCN may require prior authorization of services beyond thirty (30) calendar days. The CCN is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider.

The CCN may request to be notified by the provider, but shall not deny claims for payment based solely on lack of notification, for the following:

i. Inpatient emergency admissions within forty-eight (48) hours of admission;

ii. Obstetrical care (at first visit); and

Obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery and ninety-six (96) hours after caesarean section.

- **PCP Utilization and Quality Profiling**

The CCN shall profile its PCPs and analyze utilization data to identify PCP Utilization and/or quality of care issues. The CCN shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified. The CCN shall submit individual PCP profile reports to DHH

quarterly. CCN PCP profiling activities shall include, but are not limited to, the following:

i. Utilization of out-of-network providers – The CCN shall maintain a procedure to identify and evaluate member out-of-network provider referral utilization by its PCP panel;

ii. Specialist referrals – The CCN shall maintain a procedure to identify and evaluate member specialty provider referral utilization by its PCP panel;

iii. Emergency department utilization – The CCN shall maintain a procedure to identify and evaluate member emergency department referral utilization by its PCP panel;

iv. Hospital admits, lab services, medications, and radiology services – The CCN shall maintain a procedure to identify and evaluate member's utilization; and

v. Individual PCP clinical quality performance measures as indicated in Appendix C.

- **PCP Utilization & Quality Profile Reporting Requirements**

  The CCN shall submit profile reports quarterly with an Annual Summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than sixty (60) days prior to due date of those reports.

o **Case Management**

The CCN shall provide a Case Management Program through a process in which appropriate and cost-effective medical services, medically-related services, and social services are identified, planned, obtained and monitored. Identified members for case management are members for whom case management services are medically necessary. The process shall integrate the member's and case manager's review of the member's strengths and needs resulting in the mutually agreed upon appropriate and cost-effective treatment care plan that meets the medical, functional, social and behavioral health needs of the member.

- **Case Management Functions**

  Case management functions shall include, but are not limited to:

  i. Early identification of members who have or may have special needs;

  ii. Assessment of a member's risk factors;

  iii. Education regarding Patient-Centered Medical Home and referral to a Medical Home when appropriate;

  iv. Development of an individualized treatment care plan which must be:

     1) Developed by the member's PCP, with enrollee participation, and in consultation with any specialists caring for the member,
     2) Approved by the CCN in a timely manner if required by the CCN; and
     3) In compliance with applicable QA and UM standards

  v. Referrals and assistance to ensure timely access to providers;

  vi. Care coordination that actively links the member to providers, medical services, residential, social, community and other support services where needed;

  vii. Monitoring;

  viii. Continuity of care; and

  ix. Follow-up and documentation.

- **Case Management Policies and Procedures**

  The CCN shall submit Case Management Program policies and procedures to DHH for approval during Step 2 of the CCN Enrollment Process, annually thereafter, and subsequent to any revisions. Case Management policies and procedures shall, at a minimum,includethe following elements:

i. A process to offer voluntary participation in the Case Management Program to eligible members;

ii. Identification criteria, process, and triggers for referral and admission into the Case Management Program;

iii. The provision of an individual needs assessment and diagnostic assessment; the development of an individual treatment care plan, as necessary, based on the needs assessment; the establishment of short and long term treatment objectives; the monitoring of outcomes; and a process to ensure that treatment care plans are revised as necessary. These procedures shall be designed to accommodate the specific cultural and linguistic needs of the CCN's members; Procedures must describe collaboration processes with member's treatment providers;

iv. A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;

v. Procedures and criteria for making referrals to specialists and subspecialists and follow-up of those referrals;

vi. Procedures and criteria for maintaining treatment care plans and referral services when the member changes PCPs; and

vii. Coordinate Case Management activities for members also receiving services through the CCN's Chronic Care Management Program.

- **Identifying Special Populations**

  The mechanism for identifying members with special health care needs (SHCN) that require an assessment to determine if a course of treatment or regular care monitoring is needed includes:

i. The CCN shall utilize historical claims data (if available) to identify members who meet CCN, DHH approved, guidelines for meeting SHCN criteria.

ii. CCN PCPs shall identify members who meet SHCN criteria to the CCN.

The CCN must identify members with potential SHCN within ninety (90) days of receiving the member's historical claims data (if available). The PCP can identify members as having special needs at any time the member presents with those needs. The CCN must assess those members within ninety (90) days of identification. The assessment must be done by appropriate healthcare professionals. Assessments that determine a course of treatment or regular care monitoring is appropriate shall result in a referral for Case Management. However, during the phase-in implementation of the Coordinated Care Program, DHH will extend this requirement to one hundred and eighty (180) days from the enrollment effective date.

The CCN must have a mechanism in place to allow enrollees with special health care needs to directly access a specialist(s) (for example, through a standing referral) as appropriate for the member's condition and identified needs, in accordance with 42 CFR §438.208**.**

- **Case Management Reporting Requirements**

The CCN shall submit case management reports quarterly with an annual summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than sixty (60) days prior to the due date of those reports. The case management reports shall include, at a minimum:

i. Number of members identified with potential special healthcare needs utilizing historical claims data;

ii. Number of members with special healthcare needs identified by the member's PCP;

iii. Number of identified members with assessments;

iv. Number of members with assessments resulting in a referral for Case Management; and

v. Number of treatment care plans completed.

Chronic Care Management Program

The CCN shall provide a Chronic Care Management Program (CCMP) for members diagnosed with the following chronic conditions:

a. Asthma;
b. Diabetes; and
c. Congestive heart failure.

The CCN shall also include one of the following chronic conditions in the CCMP for its members: hypertension as a precursor to coronary artery disease and stroke; sickle cell anemia, chronic obstructive pulmonary disease (COPD), low back pain and chronic pain. Additional chronic conditions may be added at the CCN's discretion. The CCN shall include additional discretionary chronic conditions in CCMP reports, as delineated for required chronic conditions in the CCMP, to DHH.

- **CCMP Policies and Procedures**

  The CCN shall submit Chronic Care Management Program policies and procedures to DHH for approval during Step 2 of the Enrollment Process, annually and subsequent to any revisions. The CCN shall develop and implement policies and procedures that:

  - Include the definition of the target population;
  - Include member identification strategies;
  - Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;
  - Include guidelines for treatment plan development, as described in NCQA Disease Management program content, that provide the outline for all program activities and interventions;
  - Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions;
  - Include methods for informing and educating members and providers;

- Emphasize exacerbation and complication prevention utilizing evidence- based clinical practice guidelines and patient empowerment and activation strategies;
- Conduct and report the evaluation of clinical, humanistic and economic outcomes;
- Address co-morbidities through a whole-person approach;
- Coordinate CCMP activities for members also identified in the Case Management Program; and
- Include Program Evaluation requirements.

- **Predictive Modeling**

The CCN shall use predictive modeling methodology to identify and stratify members eligible for the CCMP.

The CCN shall submit specifications of its Predictive Modeling, including its risk scoring, stratum, and healthcare guidelines during Step 2 of the CCN Enrollment Process ,annually thereafter, and prior to any changes. These specifications shall include but are not limited to:

- A brief history of the tool's development and historical and current uses;
- Medicaid data elements to be used for predictors and dependent measure(s);
- Assessments of data reliability and model validity;
- A description of the rules and strategy to achieve projected clinical outcomes and how clinical outcomes shall be measured; and
- A description of how the model has been optimized on these type interventions and the constraints on intervention to the Medicaid program and population.

- **Chronic Care Management Program Reporting Requirements**

The CCN shall submit Chronic Care Management reports quarterly to DHH. DHH reserves the right to request additional reports as deemed necessary.

DHH will notify the CCN of additional required reports no less than sixty (60) days prior to due date of those reports.

- The CCMP reports shall contain at a minimum:
  - Total number of members;
  - Number of members in each stratification level for each chronic condition; and
  - Number of members who were disenrolled from the program and an explanation as to why they were disenrolled.
- The CCN shall submit an annual CCMP evaluation

Quality Management

The CCN shall have an ongoing Quality Assessment and Performance Improvement (QAPI) Program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services and promotes improved patient outcomes through monitoring and evaluation activities. Improvement strategies include, but are not limited to, performance improvement projects, medical record audits, performance measures, and surveys. The CCN shall have mechanisms to 1) detect underutilization and overutilization of services and 2) assess the quality and appropriateness of care furnished to enrollees with special health care needs.

The QAPI Program's written policies and procedures shall address components of effective healthcare management and define processes for ongoing monitoring and evaluation that will promote quality of care. High risk and high volume areas of patient care should receive priority in selection of QAPI activities.

The QAPI Program shall define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success.

The CCN shall submit its QAPI program description to DHH for written approval at the Readiness Review, and annually thereafter.

The CCN's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the CCN's governing body shall include providing strategic direction to the QAPI Program, as well as ensuring the QAPI Program is incorporated into the operations throughout the CCN.

- **QAPI Committee**
  - The CCN shall form a QAPI Committee. The CCN Medical Director must serve as either the chairman or co-chairman.

- Appropriate CCN staff representing the various departments of the organization will have membership on the committee.

- The CCN is encouraged to include a member advocate representative on the QAPI Committee.

- The QAPI Committee shall meet on a quarterly basis. Its responsibilities shall include:

  - Direct and review quality improvement (QI) activities;

  - Assure that QAPI activities take place throughout the CCN;

  - Review and suggest new and/or improved QI activities;

  - Direct task forces/committees to review areas of concern in the provision of healthcare services to members;

  - Designate evaluation and study design procedures;

  - Conduct individual PCP and practice quality performance measure profiling;

  - Report findings to appropriate executive authority, staff, and departments within the CCN;

  - Direct and analyze periodic reviews of members' service utilization patterns; and

  - Maintain minutes of all committee and sub-committee meetings. Submit meeting minutes to DHH within 5 working days of the meetings.

  - 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.

  - Ensure that a QAPI committee designee attends DHH's quality meetings.

- **QAPI Plan**

  The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body.

The QAPI plan shall be submitted to DHH for written approval during the Readiness Review, annually thereafter, and prior to revisions. The QAPI plan shall:

- Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;
- Include a description of the CCN staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities; and
- Describe the role of its providers in giving input to the QAPI Program.

- **QAPI Reporting Requirements**

The CCN shall submit QAPI reports annually to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than thirty (30) days prior to due date of those reports. The QAPI reports shall contain at a minimum:

- Quality improvement (QI) activities;
- Recommended new and/or improved QI activities; and
- Evaluation of the impact and effectiveness of the QAPI program.

- **Performance Measures**

The CCN shall collect and report clinical and administrative performance measure (PM) data in accordance with the *Quality Companion* ***Guide***. The data shall demonstrate adherence to clinical practice guidelines and/or improvement in patient outcomes. Performance Measures include Health Care Effectiveness Data and Information Set (HEDIS) measures, Agency for Healthcare Research and Quality Review (AHRQ) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures and/or other measures as determined by DHH.

The CCN shall have processes in place to monitor and self-report all required performance measures.

During the course of the Provider Agreement, DHH or its designee will actively participate with the CCN to review the results of performance measures.

DHH will monitor the CCN's performance using Benchmark Performance and Improvement Performance data. Performance measurements will be reviewed by DHH on an annual basis to assess any measurements that should be changed, added, or deleted for the next reporting period. Any changes in the money performance measures will require an amendment to the Provider Agreement and DHH will provide sixty (60) days notice of such change. Changes to non-money performance measures will require sixty (60) days notice by DHH.

The CCN shall provide systems, operations, and performance monitoring tools and/or automated methods for monitoring. The tools and reports will be flexible and adaptable to changes in the quality measurements required by DHH.

Quarterly reporting requirements will be determined by DHH and communicated annually to the CCN.

An independent, accredited auditing firm or qualified third party approved by DHH will review all data collection processes, data and audit reports on a schedule defined by DHH.

- **Performance Measurement Goals**

  Starting year 2 of the measurement year, or as otherwise specified by DHH, a maximum of 100% of eligible savings (10% for each of 10 specified Performance Measures) will be assessed for those specified performance measures that fall below DHH's performance standard. Performance measures that fall be below performance standards will require a corrective action plan (CAP).

  - The CCN shall submit a CAP, within thirty (30) calendar days of the date of notification or as specified by DHH.
  - Within thirty (30) calendar days of receiving the CAP, DHH will either approve or disapprove the CAP. If disapproved, the CCN shall resubmit, within fourteen (14) calendar days, a new CAP that addresses the concerns identified by DHH.
  - Upon approval of the CAP-whether the initial CAP or the revised CAP-- the CCN shall implement the CAP within the time frames specified by DHH.
  - The Department's performance baselines will be determined utilizing Medicaid historical claims data during the most current measurement year and, depending on the measure, will be either be:

- CCN specific, using historical claims data specific to member enrollment on the 91st day of implementation; or
- A statewide average.

Quality benchmarks for each measure will be determined by the CCN's baseline for that measure with the expectation that performance improves by a certain percentage.

Quality measures to be reported by every CCN can be found in the chart in Appendix C.

The CCN shall report all performance measures as indicated by DHH. DHH may add or remove reporting requirements with a thirty (30) day advance notice. DHH expressly reserves the right to implement alternative measures or modify existing performance incentives/disincentives.

DHH expressly reserves the right to implement alternative measures or modify existing performance incentives.

o **Performance Measure Reporting Requirements**

The CCN shall report to DHH results of all performance measures quarterly, annually and upon Department request. DHH may add or remove reporting requirements with a thirty (30) day advance notice.

o **Performance Improvement Projects**

In accordance with 42 CFR §438.240, the CCN shall have an ongoing program of performance improvement projects (PIPs) that focus on clinical and non-clinical areas. The CCN's Performance Improvement Projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time, with favorable effects on health outcomes and enrollee satisfaction. Each Performance Improvement Project shall be completed in a reasonable time period so as to generally allow information on the success of Performance Improvement Projects in the aggregate to produce new information on quality of care every year.

- The CCN shall perform a minimum of two (2) DHH approved PIPs in the first Provider Agreement year. The DHH required PIP during the first Provider Agreement year is listed in Section 1 of Appendix D - Performance Improvement Projects. The CCN shall choose the second PIP from Section 2 of

Appendix D. DHH may require an additional PIP each successive year to reach a maximum of four (4) PIPs.

- The CCN PIPs shall be designed to achieve, through ongoing measurements and interventions, significant improvement sustained over time that are expected to have a favorable effect on health outcomes and member satisfaction. Each PIP must include the following:

  i. Measurement of performance using objective quality indicators;

  ii. Implementation of system interventions to achieve improvement in quality;

  iii. Evaluation of the effectiveness of the interventions; and

  iv. Planning and initiation of activities for increasing or sustaining improvement.

- Within three (3) months of the execution of the Provider Agreement and at the beginning of each Provider Agreement year thereafter, the CCN shall submit, in writing, a general and a detailed description of each PIP to DHH for approval. The detailed PIP description shall include:

  i. An overview explaining how and why the project was selected, as well as its relevance to the CCN members and providers;

  ii. The study question;

  iii. The study population;

  iv. The quantifiable measures to be used, including a goal or benchmark;

  v. Baseline methodology;

  vi. Data sources;

  vii. Data collection methodology and plan;

  viii. Data collection cycle;

ix. Data analysis cycle and plan;

x. Results with quantifiable measures;

xi. Analysis with time period and the measures covered;

xii. Analysis and identification of opportunities for improvement; and

xiii. An explanation of all interventions to be taken.

- PIPs used to measure performance improvement shall include diagrams (e.g. algorithms and /or flow charts) for monitoring and shall:

  i. Target specific conditions and specific health service delivery issues for focused system-wide and individual practitioner monitoring and evaluation;

  ii. Use clinical care standards and/or practice guidelines to objectively evaluate the care the CCN delivers or fails to deliver for the targeted clinical conditions;

  iii. Use appropriate quality indicators derived from the clinical care standards and/or practice guidelines to screen and monitor care and services delivered;

  iv. Implement system interventions to achieve improvement in quality;

  v. Evaluate the effectiveness of the interventions;

  vi. Provide sufficient information to plan and initiate activities for increasing or sustaining improvement;

  vii. Monitor the quality and appropriateness of care furnished to enrollees with special health care needs;

  viii. Reflect the population served in terms of age groups, disease categories, and special risk status,

  ix. Ensure that appropriate health professionals analyze data;

x. Ensure that multi-disciplinary teams will address system issues;

xi. Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal benchmark;

xii. Validate the design to assure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis, and

xiii. Maintain a system for tracking issues over time to ensure that actions for improvement are effective.

- **PIP Reporting Requirements**

The CCN shall submit PIP outcomes annually to DHH. Reporting specifications are detailed in the ***Quality Companion Guide***. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than thirty (30) days prior to due date of those reports.

- **Pay for Performance**

Depending on funding availability, DHH may institute a Pay for Performance (P4P) program based on the CCN's completion of quality monitoring and improvement activities and the achievement of specific goals as determined by DHH. These goals will be designed to enhance members' access to health care services and improve program quality and efficiency of the CCN's delivery system through provider practice improvements. P4P payments may begin in year two of the Provider Agreement or a timeframe to be decided by DHH. DHH may provide financial incentives based on the CCN's performance exceeding national benchmarks indicative of excellent care and practice. DHH expressly reserves the right to implement alternative methodologies, or modify existing methodologies, for the CCN Pay for Performance program throughout the Provider Agreement period.

- **Member Satisfaction Surveys**

In order to assess the quality and appropriateness of care to members, the CCN shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys. The CCN shall enter

into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The CCN's vendor shall perform CAHPS Adult surveys, CAHPS Child surveys, and CAHPS Children with Chronic Conditions survey. Survey results shall be reported to DHH separately for each required CAHPS survey. The CAHPS survey results shall be reported separately for each CCN regional area. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the CCN at the time of the survey. The surveys shall provide valid and reliable data for results in the specific CCN service delivery area. Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards. The most current CAHPS Health Plan Survey (currently 4.0) for Medicaid/CHIP Enrollees shall be used and include:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Health Plan Customer Service
- Global Ratings

Member Satisfaction Survey Reports are due 120 days after the end of the plan year.

- **Provider Satisfaction Surveys**

The CCN shall conduct an annual provider survey to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, and utilization management processes, including medical reviews and support toward Patient Centered Medical Home implementation. The Provider Survey tool must be submitted to DHH for approval prior to administration. The CCN shall submit an annual Provider Satisfaction Survey Report that summarizes the survey methods and findings and provides analysis of opportunities for improvement. Provider Satisfaction Survey Reports are due 120 days after the end of the plan year.

- **Department Oversight**

DHH shall evaluate the CCN's QAPI, PMs, and PIPs at least one (1) time per year at dates to be determined by DHH, or as otherwise specified by the Provider Agreement or this ***Guide***.

If DHH determines that the CCN's quality performance is not acceptable, DHH will require the CCN to submit a corrective action plan (CAP) for each unacceptable performance measure. If the CCN fails to provide a CAP within the time specified, DHH will sanction the CCN in accordance with the provisions of sanctions set forth in this ***Guide*** and the Provider Agreement, and may immediately terminate all new enrollment activities and automatic assignments.

Upon any indication that the CCN's quality performance is not acceptable, DHH may restrict the CCN's enrollment activities including, but not limited to, termination of automatic assignments.

When considering whether to impose a limitation on enrollment activities or automatic assignments, DHH may take into account the CCN's cumulative performance on all quality improvement activities.

The CCN shall cooperate with DHH, the independent evaluation contractor (External Quality Review Organization), and any other Department designees during monitoring.

- **External Independent Review**

The CCN shall provide all information requested by the External Quality Review Organization (EQRO) and/or DHH.

The CCN shall cooperate with the EQRO during the review (including medical record review), which will be done at least one (1) time per year.

LEFT BLANK INTENTIONALLY

SECTION 9 – GENERAL CCN AND NETWORK PROVIDER RESPONSIBILITIES AND REQUIREMENTS

Contract Requirements

- The CCN and its providers shall participate in DHH's endeavor to move toward meaningful use of electronic health records.
- In addition to standards described in the Provider Agreement and this ***Guide***, the CCN will execute a contract with in-network providers.
- All provider contracts and amendments shall be in writing and meet the requirements set forth in the Provider Agreement, as well as, the following requirements:
    - Include a signature page which contains a CCN and provider name which are typed or legibly written, provider company with titles, and dated signature of all appropriate parties; (applicable for renewals as well)
    - Specify that the contract and its attachments contain all the terms and conditions of the Provider Agreement and any other terms and conditions agreed upon by the parties;
    - Assure that the provider shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the contract without the prior approval of the CCN;
    - Identify the population covered by the contract;
    - Specify that the provider may not refuse to provide covered medically necessary or covered preventative services to members for non-medical reasons. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;
    - Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/technical practice;
    - Specify that unreasonable delay in providing care to a pregnant member seeking prenatal care shall be considered a material breach of the contract with the CCN and include definition of unreasonable delay as described in the definitions section of this ***Guide***;
    - Include medical record requirements found in**§11.2**– *Medical Records Requirements* of the Provider Agreement.

- Contain language regarding audit requirements and availability of records;
- Provide for monitoring whether announced or unannounced, of services rendered to members;
- Specify CCN responsibilities under the Provider Agreement and this ***Guide***, including but not limited to provision of a copy of the member handbook and provider handbook;
- Specify the provider's responsibility and prohibited activities as provided in**§8.4–** *Member Rights and Responsibilities* of the Provider Agreement.
- Specify the provider's responsibilities regarding third party liability (TPL) if applicable;
- Require the provider to comply with fraud and abuse requirements described in**§14.20**– *Fraudulent Activity and* **§3.7**-*Fraud and Abuse Compliance Plan* of the Provider Agreement;
- Specify procedures and criteria for all alterations, variations, modifications, waivers, extension of the provider contract termination date, or early termination of the contract and specify the terms of such change. If the provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the provider contract, then the terms shall include provisions allowing at least thirty (30) calendar days to give notice of rejection and requiring that receipt of notification of amendment be document (e.g., certified mail, facsimile, hand-delivered, etc.);
- Specify that both parties recognize that in the event of termination of the Provider Agreement for any of the reasons described in the Provider Agreement, the provider shall immediately make available, to DHH, or it's designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the Provider Agreement. The provision of such records shall be at no expense to DHH;
- Include a lobbying clause as in **§14.1.13** of the Provider Agreement;
- Specify provider actions to improve patient safety and quality;
- Provide general and targeted language regarding emergency appeals, including when an emergency appeal is appropriate, and procedures for providing written certification thereof, and specify that the

provider shall comply with the appeal process, including but not limited to the following:

- Assisting a member by providing appeal forms and contact information including the appropriate address, telephone number and/or fax number for submitting appeals for state level review; and
- Require providers to display notices of the member's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with DHH's rules and regulations, subsequent amendments or any and all consent decrees and court orders. The CCN shall ensure that providers have a correct and adequate supply of public notices;

- Specify any monetary penalites, sanctions or reductions in payment that the CCN may assess on the provider for specific failures to comply with contractual requirements. This shall include, but may not be limited to a provider's failure or refusal to respond to the CCN's request for information, the request to provide medical records, etc.; at the CCN's discretion or a directive by DHH, the CCN shall impose at a minimum, financial consequences against the provider as appropriate;
- Include language which informs provider of the package of benefits that DHH offers and which requires providers to make treatment decisions based upon individual medical needs. DHH's requirements are contained in **§8.4** – *Members Rights and Responsibilities* of the Provider Agreement and in *Appendix G – Member's and Potential Member's Bill of Rights* of this ***Guide***. All provider contracts shall contain language that references DHH's requirements in the Provider Agreement, and the provider contract shall either physically incorporate these Sections of the Provider Agreement and ***Guide*** or include language in the contract, or to require that these sections be furnished to the provider upon request;
- Include a provision which states the provider is not permitted to encourage or suggest, in any way, that members be placed in state custody in order to receive medical or specialized behavioral health services covered by DHH;
- Require the provider to comply and submit to the CCN disclosure of information in accordance with the requirement specified in 42 CFR §455, Subpart B;
- Require that if any requirement in the provider contract is determined by DHH to conflict with the Provider Agreement between DHH and

the CCN, such requirement shall be null and void and all other provisions shall remain in full force and effect; and

- Specify allowable and unallowable network provider marketing activities.

- All model provider contracts and amendments shall be submitted in writing by the CCN to DHH for approval at least thirty (30) days in advance of implementation and the CCN shall receive written approval by DHH prior to use.

- All provider contracts shall comply with 42 CFR §438.230.

Physician Incentive Plans

The CCN shall:

- Receive DHH approval of a Physician Incentive Plan prior to implementation of such plan. The CCN shall submit to DHH any contract templates that involve a PIP for review as a material modification.

- Comply with the Physician Incentive Plan requirements set forth in Appendix M – Rules Regarding Physician Incentive Plans.

CCN Network Provider's Dispute Resolution

If disputes arise between the provider and the CCN because of the actions of the CCN, these disputes shall be settled by the provider and the CCN according to the terms of their contractual agreement.

Provider-Member Communication Anti-Gag Clause

- Subject to the limitations described in 42 §1932(b)(3)(D), the CCN shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the Provider Agreement, for the following:

  - The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

  - Any information the member needs in order to decide among relevant treatment options;

- The risks, benefits and consequences of treatment or non-treatment; and
- The member's right to participate in decisions regarding their health care, including, the right to refuse treatment, and to express preferences about future treatment decisions.

- Any CCN that violates the anti-gag provisions set forth in 42 U.S.C §1932(b)(3)(D) shall be subject to intermediate sanctions.
- The CCN shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans.

Self-Referrals

The following are circumstances in which the member may self refer:

- Within the CCN, female members for routine OB/GYN services even if the PCP provides such service

Provider Handbooks

The CCN shall develop and issue a provider handbook to all providers at the time the provider contract is signed. The CCN may choose not to distribute the provider handbook via Surface Mail, provided it submits a written notification to all providers that explains how to obtain the provider handbook from the CCN's website. This notification shall also detail how the provider can request a hard copy from the CCN at no charge to the provider. All provider handbooks and bulletins shall be in compliance with state and federal laws. The provider handbook shall serve as a source of information regarding CCN covered services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all CCN requirements are met. At a minimum, the provider handbook shall include the following information:

- Description of the CCN;
- Description and requirements of Patient-Centered Medical Home Recognition;
- Enhanced primary care case management and PCP primary care management services the CCN must provide;
- Emergency service responsibilities;

- Policies and procedures that cover the provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the CCN to file a provider complaint and which individual(s) has the authority to review a provider complaint;

- Information about the CCN's Grievance System, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers and the member's right to request continuation of services while utilizing the grievance system;

- Medical necessity standards as defined by DHH and practice guidelines;

- Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;

- PCP responsibilities;

- Other provider or contract responsibilities;

- Prior authorization and referral procedures;

- Medical records standards;

- Claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim;

- Notice that provider complaints regarding claims payment shall be sent to the CCN;

- The CCN's chronic care management program;

- Quality Performance Requirements; and

- Member rights and responsibilities.

The CCN shall disseminate bulletins as needed to incorporate any changes to the Provider Handbook.

Prior to the phase-in implementation of the Coordinate Care Program, the CCN may opt to provide generic provider handbook information. However, the CCN shall make Provider Handbooks specific to the CCN available to the Enrollment Broker no later than sixty (60) days prior to the phase-in "go live" date.

Education and Training

The CCN shall provide training to all providers and their staff regarding the requirements of the Provider Agreement, including limitations on provder marketing and identifications of special needs of members. The CCN shall conduct initial training within thirty (30) days of placing a newly contracted provider, or provider group, on active status. The CCN shall also conduct ongoing training, as deemed necessary by the CCN or DHH, in order to ensure compliance with program standards and the Provider Agreement.

The CCN shall submit a copy of the Provider Training Manual and training schedule to DHH for approval during the CCN Enrollment Process. Any changes to the manual shall be submitted to DHH at least thirty (30) calendar days prior to the scheduled change and dissemination of such change.

Provider Complaint System

The CCN shall establish a provider complaint system that permits a provider to dispute the CCN's policies, procedures, or any aspect of the CCNs administrative functions, including proposed actions. CCNs shall submit its provider complaint system policies and procedures to DHH prior to the on-site Readiness Review.

The CCN shall also distribute the provider complaint system policies and procedures to out-of-network providers upon written or verbal request. The CCN may distribute a summary of these policies and procedures, if the summary includes information about how the provider may access the full policies and procedures on the CCN's website. This summary shall also detail how the provider can request a hard copy from the CCN at no charge to the provider.

As part of the provider complaint system, the CCN shall:

- Have dedicated staff for providers to contact via telephone, electronic mail, surface mail, or in person, to ask questions, file a provider complaint and resolve problems;

- Identify a staff person specifically designated to receive and process provider complaints;

- Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying the CCN's written policies and procedures; and

- Ensure that CCN executives with the authority to require corrective action are involved in the provider complaint process. After the complete review of the provider complaint the CCN shall provide a written notice to the Provider within thirty (30) calendar days from the date of the decision.

Provider Access Component of Toll-free Telephone Line

- The CCN must operate a provider access component of the toll-free telephone line to respond to provider questions, comments and inquiries.

- The provider access component of the toll-free telephone line must be staffed between the hours 7am -7pm Central Time daily. This telephone help line will have staff to respond to provider questions in all areas, including prior authorization, provider complaints, and provider responsibilities.

- The CCN's call center system must have the capability to track provider call management metrics.

- After normal business hours, the provider service component of the toll-free telephone line must include the capability of providing information regarding normal business hours and instructions to verify enrollment for an CCN member with an emergency or urgent medical condition. This shall not be construed to mean that the provider must obtain verification before providing emergency department services and care.

TPL Reporting

The CCN shall be responsible for identifying other insurance for their enrolled members. If the CCN identifies Medicare coverage they are required to notify DHH within five (5) business days using the TPL Notification forms (See Appendices V and W). DHH will use this form to update the TPL Resource File on a daily basis. If the Department identifies coverage for a member the Enrollment Broker will be notified through the monthly X12 820 roster process.

LEFT BLANK INTENTIONALLY

SECTION 10 - MEMBER RIGHTS AND RESPONSIBILITIES

Member Welcome Packets and Calls

The Enrollment Broker shall send the CCN a weekly eligibility file in the format specified in the ***CCN-S Systems Companion Guide***. The file shall include the names, addresses and phone numbers of all new enrollees assigned to the CCN. The CCN shall use the file to identify new members to whom the CCN shall send a welcome packet within fourteen (14) calendar days from the date of receipt of the file identifying the new enrollee.

During the phase-in implementation of the CCN Program, the CCN may have up to twenty-one (21) days to provide a welcome packets.

The CCN shall make welcome calls to new members within fourteen (14) business days of receipt of the enrollment file identifying the new enrollee. The CCN shall make three (3) attempts to contact the member. If the CCN discovers that the member lost or never received the welcome packet, the CCN shall resend the packet.

The CCN shall report on a monthly basis the name, telephone number and Medicaid Recipient ID Number of each member it attempted to contact after three attempts and were unable to successfully make contact.

- Welcome Call Requirements

  The CCN shall develop and submit in Step 2 of the CCN Enrollment Process for approval a script to be used during the welcome call to discuss the following information with the member:

  - A brief explanation of the program;
  - Statement of confidentiality;
  - The availability of oral interpretation and written translation services and how to obtain them free of charge;
  - The concept of the patient-centered medical home, including the importance of the member(s) making a first appointment with his or her PCP for preventive care before the member requires care due to an illness or condition and instructions about changing PCPs; and
  - A discussion to discover whether the member is pregnant, has a chronic condition, or any special health care needs. Assistance in making an appointment with the PCP shall be offered to all members with such issues.

- Welcome Packets Requirements:

  Contents of the welcome packets shall those items specified in the Provider Agreement. Written material must use easily understood language and format and at a minimum of 6.9 grade reading 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.

Member ID Cards

Upon the member's enrollment with the CCN, the CCN shall mail the member ID card via surface mail. The members ID card shall at a minimum include, but not be limited to the following:

- The member's name and date of birth;
- The CCN's name and address for filing claims, and
- The toll-free number(s) for:
  - Member Services and Filing Grievances,
  - Provider Services, Prior Authorization, Hospital Pre-certification and
  - Reporting Medicaid Fraud (1-800-488-2917)

DHH strongly recommends the name of the individual PCP and phone number be placed on the member's card or card carrier. This information may be place on a sticker that can be affixed to the card or card carrier.

Member Call Center

- **Member Service Call Center**

  The CCN shall maintain a toll-free member service call center located in the United States with dedicated staff to respond to member questions. The CCN shall have sufficient telephone lines to answer incoming calls. The CCN shall ensure sufficient staffing to meet performance standards listed below. DHH reserves the right to specify staffing ratios and/or other requirements if performance standards are not met or it is determined that call center staffing/processes are not sufficient to meet member needs as determined by DHH.

  The CCN must develop a contingency plan for hiring call center staff to address overflow calls and emails and to maintain call center access standards set forth for

CCN performance. The CCN must develop and implement a plan to sustain call center performance levels in situations where there is high call/e-mail volume or low staff availability. Such situations may include, but are not limited to, increases in call volume, emergency situations (include natural disasters such as hurricanes), staff in training, staff illnesses and vacations.

The CCN must develop call center policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards. The CCN shall submit these policies and procedures, including performance standards, to DHH for written approval at the Readiness Review and prior to implementation of any changes. Include a capability to track and report information on each call. The CCN call center must have the capability to produce an electronic record to document a synopsis of all calls. The tracking shall include sufficient information to meet the reporting requirements.

- **Call Center Hours of Operation**

  The CCN shall accept calls at a minimum from 7 a.m. to 7 p.m. Central Time, Monday through Friday and four hours on Saturday, excluding state holidays, and be available to respond to member inquiries except for downtime for which the CCN has received prior written approval from DHH, excluding acts of God.

- **Automated Call Distribution System**

  The CCN shall install, operate and monitor an automated call distribution (ACD) system for the customer service telephone call center. The ACD system shall:

  - Effectively manage all calls received and assign incoming calls to available staff in an efficient manner;
  - Transfer calls to other telephone lines;
  - Provide detailed analysis as required for the reporting requirements, as specified, including the quantity, length and types of calls received, elapsed time before the calls are answered, the number of calls transferred or referred; abandonment rate; wait time; busy rate; response time; and call volume;
  - Provide a message that notifies callers that the call may be monitored for quality control purposes;
  - Measure the number of calls in the queue at peak times;
  - Measure the length of time callers are on hold;

- Measure the total number of calls and average calls handled per day/week/month;
- Measure the average hours of use per day;
- Assess the busiest times and days by number of calls;
- Record calls to assess whether answered accurately;
- Provide a backup telephone system that shall operate in the event of line trouble, emergency situations including natural disasters, or other problems so that access to the telephone lines are not disrupted;
- Provide interactive voice response (IVR) options that are user-friendly to members and include a decision tree illustrating IVR system; and
- Inform the member to dial 911 if there is an emergency.

- **Performance Standards**
  - Answer ninety-five percent (95%) of calls within thirty (30) seconds;
  - Maintain an average hold time of three (3) minutes or less;
  - Maintain abandoned rate of calls of not more than five percent (5%).

Provider Directory for Members

The CCN shall develop a Provider Directory in three (3) formats:

- A hard copy directory for members and upon request, potential members;
- Web-based online directory for members and the public; and
- Electronic file of the directory for the Enrollment Broker.

DHH or its designee shall provide the file layout for the electronic directory to the CCN. The CCN shall submit templates of their provider CCN directory to DHH as specified in the CCN Enrollment Process.

The hard copy directory shall be reprinted with updates at least annually. Inserts may be used to update the hard copy directories monthly for new members and to fulfill requests by potential members. The web-based online version shall be updated in real time, however, no later than weekly. The electronic version shall be updated prior to each submission to the Enrollment Broker. While daily updates are preferred, the CCN shall, at a minimum, submit updates to the Enrollment Broker no less than weekly.

The provider directory, for the network's service area, shall include but not be limited to:

- Names, locations, telephone numbers of, CCN PCPs;
- Identification of and FQHCs and RHCs in the service area;
- Identification of languages in addition to English, spoken at the provider sites;
- Identification of any restrictions on the enrollee's freedom of choice among network providers,PCPs who are not accepting new patients; and
- Identification of hours of operation including identification of providers with non-traditional hours (5:00 PM and after; weekends).

Additional Member Educational Materials and Programs

The CCN shall prepare and distribute educational materials, including, but not limited to, the following:

- Bulletins or newsletters distributed not less than four (4) times a year that provide information on preventive care, access to PCPs and other providersand other information that is helpful to members;
- The CCN may distribute other literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by the CCN. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;
- The CCN is encouraged to distribute targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;
- Materials focused on health promotion programs available to the members;
- Communications detailing how members can take personal responsibility for their health and self management;
- Materials that promote the availability of health education classes for members;
- Materials that provide education for members, with, or at risk for, a specific disability or illness;

- Materials that provide education to members, members' families and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities; and

- All materials distributed must comply with the marketing, incentive and other relevant guidelines established by DHH for these materials and/or programs.

Health Care Cost and Quality Transparency

The CCN shall include at least one article per year in member newsletters providing members with information about the cost effective use of health care (e.g., the use of brand name drugs vs. generic drugs and proper Emergency Department utilization) to assist members in making informed and appropriate decisions about health care services.

The CCN shall publish results of quality monitoring activities for metrics that demonstrate performance and quality outcomes for the CCN and its providers following the second quality measurement year as instructed by DHH.

Member Rights

The CCN shall have written policies regarding member rights. The CCN shall comply with all applicable state and federal laws pertaining to member rights and privacy. The CCN shall further ensure that the CCN's employees, contractors and CCN providers consider and respect those rights when providing services to members. Member rights shall include those rights specified in the **§8.4.1**- *MEMBER RIGHTS* of the Provider Agreement. (See Appendix G for Member's and Potential Member's Bill of Rights)

Member Responsibilities

The CCN shall encourage each member to be responsible for his own health care by becoming an informed and active participant in such care by:

- Living healthy lifestyles and avoiding behaviors known to be detrimental to their health;

- Providing accurate and complete information to their health care provider;

- Becoming knowledgeable about their CCN's coverage provisions, rules and restrictions;

- Asking questions of providers to determine the potential risks, benefits, and costs of treatment alternatives and then making care decisions after carefully weighing these and other pertinent factors; and

- Following the grievance process established by the CCN if they have a disagreement with their provider.

Members have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, provide accurate medical and personal histories, and be present at scheduled appointments and report on treatment progress, such as notifying their health care provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.

Members should report all alleged marketing violations to DHH in writing using the Marketing Complaint Form. (See Appendix Z)

Notice to Members about Provider Termination

The CCN shall make a good faith effort to give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider.

The CCN shall provide notice to a member, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within ten (10) calendar days from the date the CCN becomes aware of such, if it is prior to the change occurring.

The requirement to provide notice prior to the dates of termination, shall be waived when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the CCN, or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the CCN becoming aware of the circumstances.

LEFT BLANK INTENTIONALLY

SECTION 11 - GRIEVANCES AND STATE FAIR HEARINGS

General Requirements

The CCN shall have a grievance system in place that includes a grievance process and access to a state fair hearing. The system shall comply with the requirements set forth in all federal and state laws and regulations, including 42 CFR §431.200 and 42 CFR §§438.400 through 438.424. The CCN shall have written policies and procedures describing the grievance system. The CCN shall provide the policies and procedures to the Department for approval with the Provider Agreement submission and prior to implementation of any proposed revisions. Included in the submission of the Provider Agreement shall be a flow chart delineating the CCN's grievance process.

The CCN shall have a staff member designated as the grievance system coordinator and any additional staff necessary to comply with the requirements of this section, including those related to timeliness.

A **grievance** shall be defined as any expression of dissatisfaction by a member, other than those concerning an action. Subjects of a grievance shall include, but not be limited to, quality of care and rudeness of a provider or of a staff member of the CCN.

An **action** is one of the following;

- 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 the Department;
- The failure of the CCN to act within the timeframes for the resolution of grievances as described in this section; or
- In a rural area with only one CCN, the denial of a member's right to obtain services outside the provider CCN, as described in 42 CFR §438.52(b)(2)(ii).

The CCN shall give members reasonable assistance in completing grievance and other procedural steps, including, but not limited to, providing a toll-free telephone number, translation services, and a toll-free number with Telephone Typewriter (TTY)/Telecommunication Device for the Deaf (TDD) and interpreter capability.

The CCN shall:

- Acknowledge receipt of a grievance in writing to the member, unless the member or provider requests an expedited resolution.

- Ensure that none of the decision makers in a pending grievance to the CCN were involved in any of the previous levels of review or decision-making and that all decision makers are health care professionals with clinical expertise in treating the member's condition or disease when deciding any of the following:

    - A grievance regarding the denial or partial authorization that is based on lack of medical necessity;

    - A grievance that involves clinical issues.

- Give the member written notice of any action (not just service authorization actions) within the timeframes for each type of action.

Upon a member's enrollment with the CCN, the CCN shall provide an information packet explaining the CCN's grievance system. The packet shall include the pertinent policies and procedures, as well as specific information about filing grievances with the toll-free phone numbers, and the name and address of the grievance coordinator. The packet shall meet the requirements of **§8.4** - *Member Rights and Responsibilities* of the Provider Agreement and **§10** of this ***Guide***.

The CCN shall include information (including all related policies, procedures and time frames) regarding the grievance system in the CCN's provider manual. The CCN shall provide the manual to all providers/sub-contractors at the time the CCN enters into a contract/agreement with the provider. The information shall also be posted on the CCN web site.

The CCN shall maintain a log of all grievances and requests for fair hearings that shall be available to the Department in electronic format upon request (See Appendix L – Grievance Reporting). The CCN log shall be specific to the members covered by the Provider Agreement; entries in the log shall not be intermingled with entries about members from the CCN's other lines of business. At a minimum, the log shall contain:

- The member's name and member ID number;

- The date of filing;

- A description of the issue;

- The date of resolution;

- A description of the resolution;

- Whether the grievance was determined valid; and
- The date of member notification.

The CCN, as part of its quality improvement process, shall track the grievances to identify trends. These trends shall be reported to the QAPI committee responsible for overall quality improvement for the CCN for identification of appropriate interventions if necessary.

The CCN shall provide quarterly reports in electronic format to the Department by the fifth (5th) calendar day of the following end of the quarter, that include all grievances and, if reached, their resolutions. The reports covering the previous quarter (January-March, April-June, July-September and October-December), shall include information about any trends that have been identified and interventions that may have been implemented. These reports with PHI redacted will be made publicly available for inspection.

The CCN shall assure that no punitive action is taken against a provider who files a grievance on behalf of a member or supports a member's grievance.

CCN Grievance Process

A member, their representative, or a provider acting on behalf of the member, with written permission from the member, may file a grievance with the CCN.

The CCN shall dispose of the grievance and notify the member in writing of the resolution in a timely manner that is appropriate for the complexity of the grievance and the member's health condition. Most grievances should be resolved within ten (10) business days of receipt or sooner. All grievances shall be resolved within thirty (30) calendar days of CCN's original receipt of the grievance. Urgent and emergent grievances shall be resolved within 24 hours of receipt. There may be one extension of fourteen (14) calendar days to this timeline if:

- Requested by the member or
- The CCN can show that there is a need for additional information and that the delay is in the interest of the member. When the delay is for this reason and not as a result of a member request, the CCN shall provide information describing the reason for the delay in writing to the member; and upon request, to the Department.

Oral Grievances

When an oral grievance is filed by a member, acknowledgement of receipt of the grievance shall be considered to have been completed.

Member notification of the grievance resolution shall be made in writing within two (2) business days of the resolution.

All oral grievances and their resolutions shall be documented in the grievance log as described above.

Written Grievances

When a grievance is filed in writing, the acknowledgement of the receipt of the grievance and notice to the member explaining the resolution shall be made in writing to the member. The acknowledgement shall be made within five (5) days of receipt of the grievance; the notice of resolution shall be mailed to the member within two (2) days of the resolution.

All written grievances shall be documented in the grievance log as described and reported on a quarterly basis with an annual summary at the end of each calendar year. (See Appendix L – Grievances Reporting Requirements)

The written notice of resolution shall comply with the requirements of **§9** - *Grievance and State Fair Hearing* of the Provider Agreement and contain the following:

- The name(s), title(s) and in the case of a grievance with a clinical component, qualifying credentials of the person or persons completing the review of the grievance;
- A statement of the reviewer's understanding of the member's grievance;
- The CCN's decision in clear terms and in sufficient detail for the member to respond further to the CCN's position and if applicable, the contract basis or medical rationale shall be given;
- A reference to the evidence or documentation used as the basis for the decision, if appropriate;
- Explaination that the grievance process may be continued with DHH if they do not agree with the resolution after the member has exhausted all CCN level appeal processes; and
- The notice shall explain that the member may be advised or represented by a friend or family member, lay advocate, attorney or other representative as chosen by the member and agreed to by the representative.

The directions for requesting the additional review by the Department shall include:

- A written request for review must be submitted to the Department. The request shall be received by the Department within thirty (30) calendar days of the date on the CCN's notice of resolution;

- The request shall describe the nature of the member grievance;
- The cause of member dissatisfaction with the CCN resolution shall be included; and
- The request shall be submitted to the Department's address specified in the resolution notice.

State Fair Hearing Process

Members of a CCN may request a state fair hearing for further review of an action by the CCN when the member has received notice of an adverse decision by the CCN regarding the member's appeal of a CCN action.

The member or their representative shall submit a request for a state fair hearing to the Division of Administration – Administrative Law Judge Division (DOA) within thirty (30) calendar days from the date of the notice of resolution regarding their standard appeal. The request shall be submitted within ten (10) calendar days of the date of the notice of resolution, if the member wishes to have continuation of benefits during the state fair hearing.

Upon receipt of the member's request for a state fair hearing, DHH shall submit a copy of the request to the CCN's grienvance coordinator via fax or secure email. Within fourteen (14) calendar days of receipt of the request from the Department, the CCN shall send a copy of the member's standard appeal of the CCN's action; the contents of the standard appeal file including research, medical records and other documents used to make their decision and a summary of the member's appeal; the evidence used by the CCN to make its decision; and a copy of the notice of resolution provided to the member and to the Department.

The parties to the state fair hearing shall include the CCN, the member, their representative which may be anyone of their choosing or the representative of a deceased member's estate.

The CCN shall continue the member's benefits when:

- The CCN member or their authorized representative which may be a family member, friend, lay advocate or attorney, files the request for a state fair hearing in a timely manner, meaning on or before the later of the following:
    - Within ten (10) calendar days of the date on the notice of resolution; or
    - The intended effective date of the CCN's proposed action.
- The request involves the termination, suspension or reduction of a previously authorized course of treatment;

- The services were ordered by an authorized provider;
- The authorization had not expired; and
- The member requests extension of benefits.

An Administrative Law Judge (ALJ) at DOA shall conduct the state fair hearing. Upon the completion of the hearing, the Director of DOA shall notify the CCN, member and DHH of the hearing decision.

If the CCN, upon direction from DHH to do so, continues or reinstates the member's benefits while the hearing decision is pending, the benefits shall be continued until one of the following occurs;

- The member withdraws their request for the hearing;
- The hearing decision is adverse to the member; or
- The authorization expires or authorization service limits are met.

If the decision overturns the CCN's denial or adverse resolution:

- The CCN is required to authorize services as quickly as the member's health condition requires and within no more than ten (10) calendar days of receipt of written notification of the decision.

LEFT BLANK INTENTIONALLY

SECTION 12 – MARKETING AND OUTREACH

Marketing Definitions

Marketing activities are defined in 42 CFR §438.104 (a) as any communication from a CCN to a Medicaid/CHIP eligible, who is not enrolled in that CCN, that can be reasonably interpreted as intended to influence the recipient of the communication to enroll in that particular CCN or either to not enroll in, or to disenroll from, another CCN.

Marketing activities include verbal presentations or distribution of written materials.

Marketing materials generally include the concepts of advertising, public service announcements, printed publications, other broadcast and electronic messages designed to increase awareness and interest in the CCN. This includes any information that references the CCN, is intended for general distribution and is produced in a variety of print, broadcast or direct marketing mediums.
All marketing and outreach policies are applicable to the CCN, its agents, subcontractors, volunteers and/or providers.

All marketing activities shall be conducted in an orderly, non-disruptive manner and shall not interfere with the privacy of beneficiaries or the general community.

The CCN is responsible for distribution of its own enrollee marketing and member education materials. DHH and the DHH Enrollment Broker will only be responsible for distributing general material developed and produced by the CCN for inclusion in the enrollment package distributed to Medicaid beneficiaries. DHH will determine which materials will be included in the enrollment packet and which materials will be distributed by the CCN.

Prohibited Marketing Activities:

- Distributing plans and materials or making any statement (written or verbal) that DHH determines to be inaccurate, false, confusing, misleading or intended to defraud members or DHH. This includes statements which mislead or falsely describe covered or available services, membership or availability of providers and qualifications and skills of providers and assertions the recipient of the communication must enroll in a specific plan in order to obtain or not lose benefits or a specific CCN's plan is endorsed by the federal or state government, or similar entity.

- Portraying competitors or potential competitors in a negative manner.

- Distributing marketing information (written or verbal) that implies that a Medicaid member will be able to stay with their longtime doctor.

- Distributing marketing materials of any kind that imply that joining a particular CCN is the only means fo preserving Medicaid coverage or that CCNs or a particular CCN is the only provider of Medicaid services.

- Falsely implying that Medicaid members will have access to the same benefits and providers as a CCN's commercial members.

- Distributing CCN outreach or marketing materials or participation in CCN outreach or marketing activities prior to the successful passage of the DHH Readiness Review and the approval of the CCN marketing plan

- Attaching Medicaid application and enrollment forms to marketing materials.

- Distributing CCN outreach or marketing materials or participation in CCN outreach or marketing activities prior to the launch of the DHH Enrollment Broker's information and outreach program (applicable only during initial CCN implementation).

- Directly soliciting prospective enrollees, including person currently enrolled in CHIP or Medicaid or other CCNs.

- Comparing their CCN to another organization/CCN by name.

- Directly or indirectly engaging in door-to-door, telephone, e-mail or other cold-call marketing activites including unsolicited personal contact with a potential enrollee if the potential enrollee has not initiated the contact and marketing activities at an employer-sponsored enrollmnet event where employee participation is mandated by the employer.

- Direct mail marketing to potential enrollees, including persons currently enrolled in CHIP or Medicaid or other CCNs.

- Compensating marketing personnel through a payment structure that ties compensation to the number of persons enrolled (see Marketing Representatives entry for more details).

- Offering any gifts or material (either provided by the CCN or a third party source) with financial value, or financial gain as incentive to or conditional upon enrollment. Promotional items having no substantial resale value ($15.00 or less in value) are not considered things of financial value. Cash gifts of any amount, including contributions made on behalf of people attending a marketing event, gift certificates or gift cards are not permitted to be given to beneficiaries or the general public.

- Making reference to any health-related rewards offered by the plan (such as monetary rewards for participation in smoking cessation) in pre-enrollment marketing materials;

- Marketing or distributing marketing materials, including member handbooks, and soliciting members in any other manner, in or around public assistance offices (food stamp offices, welfare offices, Department of Social Services offices), including Medicaid/CHIP Eligibility Offices and/or Medicaid Application Centers. Medicaid/CHIP Eligibility Office staff shall be the only authorized personnel to distribute such materials.

- Using the State's or DHH's name, logo, or other identifying marks on any materials produced or issued, without the prior written consent of DHH.

- Conducting marketing or distributing marketing materials in hospital emergency rooms, including the emergency room waiting areas, patient rooms or treatment areas.

- Copyrighting or releasing any report, graph, chart, picture, or other document produced and included in whole or in part relating to services provided under this agreement on behalf of the CCN without the prior written consent of DHH.

- Purchasing or otherwise acquiring or using mailing lists of Medicaid eligibles from third party vendors, including providers and state offices.

- Using raffle tickets or event attendance or sign-in sheets to develop mailing lists of prospective enrollees.

- Charging members for goods or services distributed at events.

- Charging members a fee for accessing the CCN Website.

- Influencing enrollment in conjunction with the sale or offering of any private insurance.

- Assisting with enrollment or influencing CCN selection.

- When conducting marketing/advertising activities, the CCN shall not use their personal or provider-owned communication devices (such as a telephone or cell phone, fax machine, computer) to assist a person in enrolling in a health plan.

- Marketing to members of other CCNs. If the CCN becomes aware during a marketing encounter that an individual is enrolled in another CCN, the marketing

encounter must be promptly terminated. If the individual voluntarily suggests dissatisfaction with the CCN in which he or she is enrolled, the individual should be referred to the Enrollment Broker for assistance.

- Inducing or accepting a member's enrollment or disenrollment.
- Using terms that would influence, mislead or cause potential members to contact the CCN, rather than the DHH-designated Enrollment Broker, for enrollment.
- Making charitable contributions or donations from Medicaid/CHIP funds;
- Referencing the commercial component of the CCN in any of its CHIP or Medicaid CCN marketing materialsl
- Using terms such as "choose", "pick", "join", etc, unless the marketing materials include the Enrollment Broker's contact information.

Allowable Activities

The CCN shall be permitted to perform the following marketing activities:

- Distribute general information through mass media (i.e. newspapers, magazines and other periodicals, radio, television, the Internet, billboards, public transportation advertising, and other media outlets), in keeping with prohibitions to placement noted above.
- Make telephone calls, mailings and home visits to members currently enrolled in the CCN's plan, for the sole purpose of educating them about services offered by or available through the CCN.
- Respond to verbal or written requests for information made by potential members. The content of these specific mailings, including a plan that includes the circumstances tha will initiate distribution of such materials, must be approved by DHH prior to distribution. These materials must refer enrollment inquiries to the Enrollment Broker and should follow the written guidelines in Appendix O of this ***Guide***.
- Distribute brochures and display posters at provider offices and clinics that inform patients that the clinic or provider is part of the CCN's provider network, provided that all CCNs in which the provider participates have an equal opportunity to be represented (see additional details under CCN Providers and Marketing int this section).

- Provide promotional give-aways that exceed the fifteen dollar ($15.00) value to current members only.

- Attend or organize activities that benefit the entire community such as health fairs or other health education and promotion activities.

- Attend activities at a business at the invitation of the entity. Notification to DHH must be made of the activity and details must be provided about the planned marketing activities. The CCN may not engage in marketing activities at an employer-sponsored enrollment event where employee participation is mandated by the employer.

- Conduct telephone marketing only during incoming calls from potential members. The CCN may return telephone calls to potential members only when requested to do so by the caller. All telephone inquiries related to enrollment in Medicaid/CHIP must be referred to the DHH toll free number.

- Send plan-specific materials to potential members at the potential member's request.

Reporting Alledged Marketing Violations

To ensure the fair and consistent investigation of alleged violations, DHH has outlined the following reporting guidelines

Alleged marketing violations must be reported to DHH in writing (using the attached Marketing Complaint Form, Appendix Z).

Upon written receipt of allegations, DHH will:

1. Acknowledge receipt, in writing, within five (5) business days from the date of receipt of the allegation.

2. Begin investigation within five (5) business days from receipt of the allegation and complete the investigation within 30 calendar days. DHH may extend the time for investigation if there are extenuating circumstances.

3. Analyze the findings and take appropriate action (see Sanctions, Section ##?, for addition details).

4. Notify the complainant after appropriate action has been taken.

CCN Provider Recruitment Guidelines

Prohibited Activities

The recruitment of a solid provider network is essential to the success of a CCN. For the security of the members and provider members, CCNs shall not:

- Distribute provider recruitment materials that have not been submitted in advance to DHH for review and comment.
- Materials shall not include any statement that is inaccurate, false, confusing, misleading or intended to defraud potential provider members or DHH. This includes but is not limited to any statement that asserts that any specific CCN is endorsed by the federal or state government or a similar entity.
- Portray competitors or potential competitors in a negative manner.
- Imply that a specific CCN is the only option for maintaining current Medicaid patients or the only provider of Medicaid covered services.
- Use DHH program logos or state or federal seals or logos.

CCN Provider Recruitment Material Review Process

The CCN must submit to DHH for review and prior written (which may be via e-mail) comment all recruitment materials for providers.

All proposed recruitment materials should be submitted to DHH using the Materials Review Form. (See Appendix II) Materials should be submitted in both Word and PDF format, unless an alternative format is approved or requested by DHH.

- DHH will review the submitted provider recruitment materials and comment on changes recommended within fourteen (14) days from the date of submission.
- Once provider recruitment materials are reviewed in writing by DHH, the CCN shall submit an electronic version (PDF) of the final printed product, unless otherwise specified by DHH, within ten (10) calendar days from the print/distribution date. If DHH requests that original prints be submitted in hard copy, photo copies may not be submitted for the final product. Upon request, the CCN must provide additional original prints of the final product to DHH.

- Prior to substantially modifying any previously reviewed provider recruitment material, the CCN shall submit for review by DHH, a draft of the proposed modification.

- DHH reserves the right to notify the CCN to discontinue or modify provider recruitment materials after review and comment.

CCN Providers and Marketing

- When conducting any form of marketing in a provider's office, the CCN must acquire and keep on file, the written consent of the provider.
- The CCN may not require its providers to distribute CCN-prepared communications to their patients.
- The CCN may not provide incentives or give-aways to providers for the purpose of distributing them to CCN members or potential CCN members.
- The CCN may not conduct member education in common areas of provider offices.
- The CCN may not allow providers to solicit enrollment or disenrollment in a CCN, or distribute CCN-specific materials at a marketing activity.
- The CCN shall instruct participating providers regarding the following communication requirements:
    - Participating providers who wish to let their patients know of their affiliations with one or more CCNs must list each CCN with whom they have contracts.
    - Participating providers may display and/or distribute health education materials for ALL contracted CCNs or they may choose not to display and/or distribute for ANY contracted CCNs. Health education materials must adhere to the following guidance:
        - Health-related posters cannot be larger than 16" X 24";
        - Children's books, donated by CCNs, must be in common areas;
        - Materials may have the CCNs name, logo, phone number and Web site; and
        - Providers are not required to distribute and/or display all health education materials provided by each CCN with whom they contract. Providers can choose which items to display, as long as they distribute one or more items from each contracted CCN.

- Providers may display marketing materials for CCNs provided that appropriate notice is conspicuously and equitably posted for all CCNs with whom the provider has a contract.
- Providers must display stickers submitted by ***all*** contracted CCNs or choose to not display stickers for ***any*** contracted CCNs.
    - CCN stickers indicating the provider participates with a particular health plan cannot be larger than 5" x 7" and not indicate anything more than "the health plan is accepted or welcomed here."
- Providers may inform their patients of the benefits, services and specialty care services offered through the CCNs in which they participate. However, providers may not recommend one CCN over another CCN, offer patients incentives for selecting one CCN over another, or assist the patient in deciding to select a specific CCN.
- Upon termination of a provider agreement with the CCN, a provider that has contracts with other CCNs that offer Medicaid products may notify their patients of the change in status and the impact of such a change on the patient.

Marketing Representatives

- All CCN marketing representatives, including subcontractors assigned to marketing, must successfully complete a training program about the basic concepts of Louisiana Medicaid, Coordinated Care Networks and the enrollees' rights and responsibilities relating to enrollment in CCNs and grievance and State Fair Hearing rights. The CCN must provide a copy of the training curriculum to DHH as part of the marketing plan.
- The CCN shall ensure that all marketing representatives engage in professional and courteous behavior. The CCN shall neither participate nor encourage nor accept inappropriate behavior by its marketing representatives, including but not limited to interference with other CCN presentations or talking negatively about other CCNs.
- The CCN shall not offer compensation to a marketing representative, including salary increases or bonuses, based solely on the number of individuals they enroll. Compensation may be based on periodic performance evaluations which consider enrollment productivity as one of several performance factors.
- Sign-on bonuses for marketing representatives are prohibited.
- The CCN shall keep written documentation of the basis it uses for awarding bonuses or increasing the salary of marketing representatives and employees involved in marketing and make such documentation available for inspection by DHH.

State Approval of Materials

The CCN must submit a detailed marketing plan to DHH with the Provider Agreement for review and approval.

The marketing plan must meet CCN-S Marketing Guidelines, as detailed in **§7** of the Provider Agreement and **§12** and Appendix O of this ***Guide***.

The CCN must have a final, DHH-approved marketing plan prior to the start of any marketing efforts. CCN marketing efforts shall not begin earlier than ninety (90) calendar days prior to the provision of services by a CCN in any CCN implementation phase. Any changes to the marketing plan must be submitted to DHH for approval at least thirty (30) days before implementation of the marketing activity, unless the CCN can demonstrate just cause for an abbreviated timeframe.

The CCN shall be subject to corrective action or sanctions in the event marketing plans are implemented and/or marketing materials are distributed prior to DHH approval.

The marketing plan shall include, but is not limited to:

- Stated marketing goals and strategies.

- A marketing calendar for the year that addresses all marketing areas: advertising plans, coverage areas, Web site development and launch plans, printed materials, material distribution plans (including specific locations), outreach activities (health fairs, area events, etc.). If a CCN plans to participate in more than one phase of implementation, the marketing calendar should be divided by phases.

- Distribution methods and schedules for all materials, including media schedules for electronic or print advertising (include date and station or publication).

- The CCN's plan to incorporate the CMS "Text 4 Baby" initiative, a free mobile health service that provides health information through SMS text messages to pregnant women and new mothers during the baby's first year. Information on the program is available at www.text4baby.org.

- The CCNs' plan for equitable coverage of its entire service area, including how the CCN plans to meet the informational needs, relative to marketing, for the physical and cultural diversity of its prospective enrollees. This may include, but not be limited to, a description of provisions for non-English speaking prospective enrollees, interpreter services, alternate communication mechanisms (such as sign language, Braille, audio tapes).

- A list of all contractors engaged in marketing for the CCN.

- A copy of the CCN training curriculum for marketing representatives.

- The CCN's plans to monitor and enforce compliance with all marketing guidelines, in particular the monitoring of prohibited marketing methods.

- Copies of all marketing materials (print and multimedia) or descriptions of concepts for marketing materials the CCN or any of its contractor's plans to distribute that are in accordance with DHH's Person First Language Policy (See Appendix S) and Marketing Guidelines (Appendix O).

Neither the CCN nor its contractors shall distribute any marketing or member-related materials without prior, written approval from DHH. Materials that require review and approval include, but are not limited to:

- Marketing materials.
- Member materials (provider directories, member handbooks, member ID cards, etc.)
- Information to be used on the CCN's Web site or the Internet.
- Print Media
- Television and Radio advertisement, storyboards and scripts
- Member participation materials
- Provider recruitment materials

In order to expedite the recruitment process for CCNs, DHH is requesting the opportunity to review and comment on provider recruitment marketing materials prior to receiving the CCN Marketing Plan.

The CCN must provide a monthly report in a format prescribed by DHH (See Appendix U – Marketing Plan Monthly Report) to demonstrate the progression of the marketing plan. The quarterly report must be provided by the 10th day of the following month and include a listing of all completed marketing activities and distributed marketing materials.

The CCN must review all their marketing materials on an annual basis and revise materials, if necessary, to reflect current practices. Any revisions must be approved by DHH prior to distribution.

A summary report of all marketing efforts must be submitted to DHH within thirty days of the end of the calendar year.

Approval Process

The CCN must submit to DHH for review and prior written (which may be via e-mail) approval all outreach, marketing, member or health education materials for enrolles or potential enrollees that will be distributed to members or potential members and activities and events (outreach, marketing, and health education) for potential or current members.

This includes, but is not limited to, member handbooks, provider directories, promotional items, member newsletters, advertisements, public service announcements, billboards, bus posters, electronic messages, identification cards, fact sheets, notices, brochures, form letters, mass mailings or e-mailings, member education and outreach activities and system generated letters.

All proposed outreach, marketing, member and health education activities must be submitted to DHH using the CCN Marketing Material Submission Form, located in Appendix BB.

All materials must be submitted to DHH with the Marketing Material Submission Form. (See Appendix BB) Materials must be submitted in PDF format unless an alternative format is approved or requested by DHH.

Materials developed by a recognized entity having no association with the CCN that are related to specific diseases or general health improvement must be submitted for approval as well.

- DHH will review the submitted marketing materials and either approve, deny or submit changes within thirty (30) days from the date of submission. DHH reserves the right to require discontinuation of any marketing or member materials that violate the terms of the marketing policies.

- Once member materials are approved in writing by DHH, the CCN shall submit an electronic version (PDF) of the final printed product, unless otherwise specified by DHH, within ten (10) calendar days from the print date. If DHH requests that original prints be submitted in hard copy, photo copies may not be submitted for the final product. Upon request, the CCN must provide additional original prints of the final product to DHH.

- Prior to modifying any approved member material, the CCN shall submit for written approval by DHH, a detailed description of the proposed modification accompanied by a draft of the proposed modification.

- DHH reserves the right to notify the CCN to discontinue or modify member materials after approval.

Website Requirements

The CCN Web site must include general information about its CCN as it related to the Louisiana CHIP/Medicaid Programs. This may be developed on a page within its exiting Web site to meet these requirements.

The CCN must notify DHH when the Web site is in place and when approved updates are made.

The CCN must remain HIPAA-compliant when providing member eligibility or member identification information on the Web site.

The CCN Web site must follow all written marketing guidelines included in Appendix O of this Policy and Procedure Guide.

The CCN must provide the following information on its website, and such information shall be easy to find, navigate, and understand:

- The most recent version of the Member Handbook;
- Telephone contact information, including a toll-free customer service number prominently displayed and a Telecommunications Device for the Deaf (TDD) number;
- A list of network providers with a designation of open versus closed panels, updated at least quarterly;
- The link to the Enrollment Broker's website and toll free number for questions about enrollment;
- A section for the CCN's providers that includes contact information, claims submittal information, prior authorization instructions, and local and home office toll-free telephone numbers;
- General customer service information; and
- Information on how to file grievances and request a State Fair Hearing.

LEFT BLANK INTENTIONALLY

SECTION 13 SYSTEM AND TECHNICAL REQUIREMENTS

The CCN shall maintain a manual or automated Management Information System (MIS), hereafter referred to as System, which accepts provider claims, verifies eligibility, validates prior authorization, pre-processes, and submits claims data to DHH's FI that complies with DHH and federal reporting requirements. DHH encourages the use of automation at the CCN's earliest opportunity. The CCN shall ensure that its System meets the requirements of the Provider Agreement and all applicable state and federal laws, rules and regulations, including Medicaid confidentiality and HIPAA and American Recovery and Reinvestment Act (ARRA) privacy and security requirements.

The System shall have and maintain capacity sufficient to handle the workload projected for the begin date of operations and shall be scalable and flexible so that it can be adapted as needed, within DHH specified timeframes, in response to changes in the Provider Agreement requirements. The CCN, through the MNRO, shall provide service authorization for all services that require service authorization. The System shall have the capacity to pre-process all claims and submit claims for payment on a fee-for-service basis to the FI.

The CCN shall meet, as requested by DHH, with work groups or committees to coordinate activities and develop system strategies that actively reinforce the healthcare reform initiative.

The CCN shall be submit pre-processed claims data to the FI in either an 837 electronic format or a paper claim, whichever was originally submitted by the billing provider.

Where deemed necessary by DHH, for the CCN's Web presence to be incorporated to any degree to DHH's web presence/portal ,the CCN shall conform to all applicable state standards for website structure, coding, and presentation.

Data and Document Management Requirements

- **Adherence to Standards**

  The System shall conform and adhere to the data and document management standards of the FI including standard transaction code sets.

- **Confidentiality, Privacy, and Security**

  The CCN shall comply with all applicable state and federal confidentiality requirements, including, but not limited to, the provisions of the HIPAA standards for data and document management, security, and privacy.

- **System Accessibility**

  The CCN's application systems foundation should employ the relational data model in its database architecture, which would entail the utilization of a

relational database management system (RDBMS) such as Oracle®, DB2®, or SQL Server®. It is important that the application system support query access using Structured Query Language (SQL). Other standard connector technologies, such as Open Database Connectivity (ODBC) and/or Object Linking and Embedding (OLE), are desirable.

- **Data and Document Relationship**

  The System shall house indexed electronic images of documents to be used by members and providers to transact with the CCN and that are reposed in appropriate database(s) and document management systems (i.e., Master Patient Index) as to maintain the logical relationships to certain key data such as member identification, service authorization numbers, provider identification numbers and claim identification numbers. The CCN shall ensure that records associated with a common event, transaction or customer service issue have a common index that will facilitate search, retrieval and analysis of related activities, such as interactions with a particular member about a reported problem.

- **Retention**

  The CCN shall implement Optical Character Recognition (OCR) technology that minimizes manual indexing and automates the retrieval of scanned documents. The CCN shall provide DHH online retrieval and access to documents and files for six (6) years in live systems, for audit and reporting purposes, and ten (10) years in archival systems. Services which have a once in a life-time indicator (i.e., appendix removal, hysterectomy, etc.) are denoted on DHH's procedure formulary file and claims shall remain in the CCNs current/active claims history that is used in claims editing and are not to be archived or purged.

  Online access to claims pre-processing data shall be by the Medicaid recipient ID, provider ID and/or ICN (internal control number) to include pertinent claims data and claims status. The CCN shall provide forty-eight (48) hour turnaround or better on requests for access to information that is up to six (6) years old and seventy-two (72) hour turnaround or better on requests for access to information in machine readable form that is between six (6) to ten (10) years old. If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.

- **Information Ownership**

  All information, whether data or documentation, and reports that contain or reference information involving or arising out of the Provider Agreement is owned by DHH. The CCN is expressly prohibited from sharing or publishing DHH's information and reports without the prior written consent of DHH. In the event of a dispute regarding the sharing or publishing of information and reports, DHH's decision on this matter shall be final.

System and Data Integration Requirements

- **Adherence to Standards for Data Exchange**

  The System shall be able to transmit, receive, and process data in HIPAA-compliant or DHH specific formats and/or methods, including but not limited to, secure File Transfer Protocol (FTP) over a secure connection, such as a VPN, that are approved during Step 3 of the CCN Enrollment Process. Data elements and file format requirements may be found in the ***CCN-S Systems Companion Guide.*** The CCN shall maintain desktop workstation hardware and software compatible with current DHH standards as follows:

  - Desktop Workstation Hardware:
    - IBM-compatible PC using at least a Dual Core Processor (2.66 GHz, 6 MB cache, 1333 MHz FSB);
    - At least 4 GB (gigabytes) of RAM;
    - At least 250 GB HDD;
    - 256 MB discrete video memory;
    - A color monitor or LCD capable of at least 800x640 screen resolution;
    - A DVD +/-RW and CD-ROM drive capable of reading and writing to both media; and
    - 1 gigabyte Ethernet card.
  - Desktop Workstation Software:
    - Operating system should be Microsoft Windows XP SP2 or later;

- Web browser that is equal to or surpasses Microsoft Internet Explorer v7.0 and is capable of resolving JavaScript and ActiveX scripts;
- An e-mail application that is compatible with Microsoft Outlook;
- An office productivity suite such as Microsoft Office that is compatible with Microsoft Office 2007 document standards;
- Each workstation should have access to the Internet;
- A desktop compression/encryption application that is compatible with WinZIP v11.0;
- Each workstation connected to the Internet should have anti-virus, anti-spam, and anti-malware software. Regular and frequent updates of the virus definitions and security parameters of these software applications should be established and administered; and
- All workstations, laptops and portable communication devices shall be installed with full disk encryption software.

The CCN shall comply with DHH's Electronic Claims Data Interchange (eCDI) annual certification of electronically submitted claims.

- **HIPAA Compliance**

  All HIPAA-conforming exchanges of data between DHH and the CCN are subject to the highest level of compliance as measured using an industry-standard HIPAA compliance checker. The Provider Agreement is inclusive of the HIPAA Business Associate Appendix to the Provider Ageement (see Appendix E of the Provider Agreement).

- **Connectivity and Interoperability**

  All applications, operating software, middleware, and networking hardware and software shall be interoperable with DHH's systems as needed and shall conform to applicable standards and specifications set forth by DHH. The System shall have the capability to transmit and receive claims data to and from the FI's system as required for the appropriate submission of claims data.

The CCN shall not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the CCN's span of control.

The CCN shall maintain computer hardware and software that provides the following established capabilities:

- Establish a local area network or networks as needed to connect all appropriate workstation personal desktop computers (PCs).
- Establish internet connection(s) so that all appropriate workstation PCs are able to access the Internet.
- Establish appropriate hardware firewalls, routers, and other security measures so that the CCN computer network is not able to be breached by an external entity.
- Establish appropriate back-up processes that ensure the back-up, archival, and ready retrieval of network server data and desktop workstation data.
- Ensure that network hardware is protected from electrical surges, power fluctuations, and power outages by using the appropriate uninterruptible power system (UPS) and surge protection devices.
- The CCN shall establish independent generator back-up power capable of supplying necessary power for four (4) days.

If a system update or change are necessary, the CCN shall draft appropriate revisions for the documentation or manualsfor DHH review and approval and submit to DHH thirty (30) days prior to implementation of the revision. Documentation revisions shall be accomplished electronically and shall be made available for DHH review in an easily accessible, near real-time method. Printed manual revisions shall occur within ten (10) business days of the actual revision.

The Medicaid Management Information System (MMIS) processes claims and payments for covered Medicaid services. DHH's current MMIS contract expires December 31, 2010. DHH may exercise its right to extend all or part of a five (5) year extension to its current FI. DHH shall require the CCN to comply with transitional requirements as necessary, at no cost to DHH or its FI, should DHH contract with a new FI during the Provider Agreement.

- **Program Integrity (Fraud and Abuse)**

The System shall be capable of generating files in prescribed formats for uploading to the FI's system that is used specifically for program integrity and

compliance purposes. The CCN shall allow DHH personnel, agents of the Louisiana Attorney General's Office or individuals authorized by DHH or the Louisiana Attorney General's Office direct access to its system(s).

Pre-Processed Claims Data Submission

The System is required to conform to current HIPAA standard code sets.

The CCN shall submit all pre-processed clean claims data to the FI via standard transaction formats within two (2) business days of receipt of the clean claim from the provider. Information required which supports claims data reporting and submission is defined in the ***CCN-S Systems Companion Guide***.

- The System shall, at a minimum, be capable of meeting the requirements listed below:
    - All claims shall be submitted either on paper or electronically in the standard HIPAA transaction formats, specifically the ANSI X12N 837 Transaction formats (P - Professional, and I - Institutional), and depending upon how the original claim was submitted to the CCN. Compliance with all applicable HIPAA, federal and state mandates, both current and future is required.
    - The CCN shall have the ability to update CPT/HCPCS, ICD-9-CM, and other codes based on HIPAA standards and move to future versions as required.
    - In addition to CPT, ICD-9-CM and other national coding standards, the use of applicable HCPCS Level II and Category II CPT codes are mandatory, aiding the CCN and DHH to measure quality performance.
    - The CCN shall provide the FI with complete and accurate claims data for all levels of healthcare services.
- MMIS identifies valid and invalid claims from a batch submission by the CCN. Any submission, which contains fatal transaction format errors that prevent processing, or that does not satisfy defined threshold error rates, will be rejected and returned to the CCN for immediate correction.
- The CCN shall utilize DHH provider billing manuals and become familiar with the claims data elements that must be included in claims submissions. Due to the need for timely filing of data and to maintain integrity of processing sequence, the CCN shall address any issues that prevent processing of a claim.

Eligibility and Enrollment Data Exchange

- The CCN shall:
  - Receive, process and update enrollment files sent daily by the Enrollment Broker;
  - Update its eligibility and enrollment databases within twenty-four (24) hours of receipt of said files;
  - Transmit to DHH, in the formats and methods specified in the HIPAA guide or as otherwise specified by DHH, member address changes, telephone number changes;
  - Be capable of uniquely identifying (i.e., Master Patient Index) a distinct Medicaid member across multiple populations and Systems within its span of control;
  - Be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by DHH, resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

Provider File

At the onset of the CCN Provider Agreement and periodically as changes are necessary, DHH shall publish a Medicaid provider list at www.lamedicaid.com which includes provider types, specialty, and sub-specialty codes. The CCN shall utilize these codes within their provider file record. The objective is to coordinate the provider file records of the CCN with the same provider type, specialty and sub-specialty codes as those used by DHH and the Enrollment Broker.

- The CCN shall:
  - Have the ability to electronically receive, process and update the provider information within their network in a database so that the Enrollment Broker is able to electronically access and identify available PCPs for member linkage.
  - Have the ability to create an electronic data file containing information on all Medicaid providers for service authorization and analysis purposes.

Provider file should include, at a minimum, the following functionality:

- Linkages of individual providers to groups;

- Provider office hours;
- PCP capacity; and
- Provider languages spoken.

System, Information Security and Access Management

- The System shall:
  - Employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:
    - Restrict access to information on a "least privilege" basis, such as users permitted inquiry privileges only, will not be permitted to modify information;
    - Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions shall be restricted to specified staff jointly agreed to by DHH and the CCN; and
    - Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.
  - Make System information available to duly authorized representatives of DHH and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.
  - Contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed jointly by and mutually agreed upon by the CCN and DHH.
  - Ensure that audit trails be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:
    - Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

- Have the date and identification "stamp" displayed on any on-line inquiry;
- Have the ability to trace data from the final place of recording back to its source data file and/or document;
- Be supported by listings, transaction reports, update reports, transaction logs, or error logs;
- Facilitate auditing of individual records as well as batch audits; and
- Be maintained online for no less than six (6) years; additional history shall be retained for no less than ten (10) years and shall be provide forty-eight (48) hour turnaround or better on request for access to information in machine readable form, that is between six (6) to ten (10) years old.

o Have inherent functionality that prevents the alteration of finalized records;

o Provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The CCN shall provide DHH with access to data facilities upon request. The physical security provisions shall be in effect for the life of the Agreement;

o Restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access;

o Include physical security features designed to safeguard processor sites through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel;

o Put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of a CCN and or its contractor's span of control. This includes, but is not limited to, any provider or member service applications shall be directly accessible over the Internet and shall be appropriately isolated to ensure appropriate access;

o Ensure that remote access users of its System can only access said System through two-factor user authentication such as Virtual Private Network (VPN), which must be prior approved by DHH during Step 3 of the CCN Enrollment Process; and

- Comply with recognized industry standards governing security of state and federal automated data processing systems and information processing. At a minimum, the CCN shall conduct a security risk assessment and communicate the results in an information security plan provided during Step 3 of the CCN Enrollment Process. The risk assessment shall also be available to appropriate federal agencies.

System Availability

- The CCN shall:
  - Ensure that critical member and provider Internet and/or telephone-based IVR functions and information functions are available to the applicable System users twenty-four (24) hours a day, seven (7) days a week except during periods of scheduled System unavailability agreed upon by DHH and the CCN. Unavailability caused by events outside of the CCN's span of control is outside of the scope of this requirement;
  - Ensure that at a minimum all other System functions and information are available to the applicable system users between the hours of 7a.m. and 7p.m., Central Time, Monday through Friday;
  - Ensure that the systems and processes within its span of control associated with its data exchanges with the FI and/or Enrollment Broker are available and operational;
  - Ensure that in the event of a declared major failure or disaster, the CCN core eligibility/enrollment and claims processing systems shall be back on line within seventy-two (72) hours of the failure or disaster occurrence;
  - The CCN shall notify applicable DHH staff via phone, fax and/or electronic mail within sixty (60) minutes upon discovery of a problem within or outside of the CCN's span of control that may jeopardize or is jeopardizing availability and performance of critical systems functions and the availability of critical information as defined in this Section, including any problems impacting scheduled exchanges of data between the CCN and DHH. In its notification, the CCN shall explain in detail the impact to critical path processes such as enrollment management and claims submission processes;
  - The CCN shall notify applicable DHH staff via phone, fax, and/or electronic mail within fifteen (15) minutes upon discovery of a problem that results in delays in report distribution or problems in on-

line access to critical systems functions and information during a business day, in order for the applicable work activities to be rescheduled or handled based on System unavailability protocol;

- Provide information on System unavailability events, as well as status updates on problem resolution, to appropriate DHH staff. At a minimum these updates shall be provided on an hourly basis and made available via phone and/or electronic mail;

- Resolve and implement system restoration within sixty (60) minutes of official declaration of unscheduled System unavailability of critical functions caused by the failure of system and telecommunications technologies within the CCN's span of control. Unscheduled System unavailability to all other System functions caused by system and telecommunications technologies within the CCN's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of System unavailability;

- Cumulative System unavailability caused by systems and/or IS infrastructure technologies within the CCN's span of control shall not exceed twelve (12) hours during any continuous twenty (20) business day period;

- Within five (5) business days of the occurrence of a problem with system availability, the CCN shall provide DHH with full written documentation that includes a corrective action plan describing how the CCN will prevent the problem from reoccurring ; and

- Not be responsible for the availability and performance of systems and IS infrastructure technologies outside of the CCN's span of control.

Contingency Plan

The CCN, regardless of the architecture of its System, shall develop and be continually ready to invoke a contingency plan to protect the availability, integrity, and security of data during unexpected failures or disasters, (either natural or man-made) to continue essential application or system functions during or immediately following failures or disasters.

Contingency plans include a disaster recovery plan (DRP) and a business continuity plan (BCP). A DRP is designed to recover systems, networks, workstations, applications, etc. in the event of a disaster. A BCP shall focus on restoring the operational function of the organization in the event of a disaster and includes items related to IT, as well as operational items such as employee notification processes and the procurement of office supplies needed to do business in the emergency mode operation environment. The practice of including both the DRP and the BCP in the contingency planning process is a best practice.

The CCN shall have a Contingency Plan that will be reviewed and approved by DHH during the Readiness Review. Minimum requirements of the Contingency Plan are defined below.

At a minimum, the Contingency Plan shall address the following scenarios:

- The central computer installation and resident software are destroyed or damaged;
- The system interruption or failure resulting from network, operating hardware, software, or operations errors that compromise the integrity of transaction that are active in a live system at the time of the outage;
- System interruption or failure resulting from network, operating hardware, software or operations errors that compromise the integrity of data maintained in a live or archival system;
- System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system, but does prevent access to the System, such as it causes unscheduled System unavailability; and
- The Plan shall specify projected recovery times and data loss for mission-critical systems in the event of a declared disaster.

The CCN shall annually test its plan through simulated disasters and lower level failures in order to demonstrate to DHH that it can restore System functions.

In the event the CCN fails to demonstrate through these tests that it can restore System functions, the CCN shall be required to submit a corrective action plan to DHH describing how the failure shall be resolved within ten (10) business days of the conclusion of the test.

Off Site Storage and Remote Back-up

The CCN shall provide for off-site storage and a remote back-up of operating instructions, procedures, reference files, system documentation, and operational files.

- The data back-up policy and procedures shall include, but not be limited to:
    - Descriptions of the controls for back-up processing, including how frequently back-ups occur;
    - Documented back-up procedures;
    - The location of data that has been backed up (off-site and on-site, as applicable);

- The policies and procedures of such off-site location including compliance with HIPAA security rules;
- The contractor must agree to produce, at its expense, legible hard copy records upon the request of state or federal authorities, within fifteen (15) calendar days of the request;
- Identification and description of what is being backed up as part of the back-up plan; and
- Any change in back-up procedures in relation to the CCN technology changes.

DHH shall be provided with a quarterly list of all back-up files stored at remote locations and the frequency with which these files are updated.

System User and Technical Support Requirements

The CCN shall provide Systems Help Desk services to Providers, DHH, the FI, and Enrollment Broker staff that have direct access to the CCN System.

- The Systems Help Desk shall:
  - Be available via local and toll-free telephone service, and via e-mail from 7a.m. to 7p.m., Central Time, Monday through Friday, with the exception of DHH designated holidays. Upon request by DHH, the CCN shall be required to staff the Systems Help Desk on a state holiday, Saturday, or Sunday;
  - Answer questions regarding the CCN System functions and capabilities; report recurring programmatic and operation problems to appropriate staff for follow-up; redirect problems or queries that are not supported by the Systems Help Desk, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate DHH staff;
  - Ensure individuals who place calls after hours are able to leave a message. The CCN staff shall respond to messages left between the fours of 7:00 p.m. and 7:00 a.m. by noon the next business day;
  - Ensure recurring problems not specific to System unavailability identified by the System Help Desk shall be documented and reported to CCN management within one (1) business day of recognition so that deficiencies are promptly corrected; and

- Have an IS service management system that provides an automated method to record, track and report all questions and/or problems reported to the Systems Help Desk.

System Testing and Change Management Requirements

- The CCN shall notify DHH staff of the following changes to System within its span of control within at least ninety (90) calendar days of the projected date of the change:
  - Major changes, upgrades, modification, conversions or updates to application or operating software associated with the following core production System:
    - Claims pre-processing;
    - Medicaid recipient eligibility verification processing;
    - Service authorization management; and
    - Provider file and data management.
  - The CCN shall respond to DHH notification of System problems not resulting in System unavailability according to the following timeframes:
    - Within five (5) calendar days of receiving notification from DHH, the CCN shall respond in writing to notices of system problems.
    - Within fifteen (15) calendar days, the correction shall be made or a requirements analysis and specifications document will be due.
    - The CCN shall correct the deficiency by an effective date to be determined by DHH.
    - The CCN System shall have a system-inherent mechanism for recording any change to a software module or subsystem.
    - The CCN shall put in place procedures and measures for safeguarding against unauthorized modification to the CCN System.
- **Valid Timeframe for System Changes**

Unless otherwise agreed to in advance by DHH as part of the activities described above, the CCN shall not schedule System unavailability to perform system maintenance, repair and/or upgrade activities to take place during hours that can compromise or prevent critical business operations.

- **Testing**

  The CCN shall work with DHH pertaining to any testing initiative as required by DHH and shall provide sufficient system access to allow testing by DHH and/or its FI of the CCN System during Step 3 of the CCN Enrollment Process.

Information Systems Documentation Requirements

The CCN shall:

- Ensure that written System process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems;
- Develop, prepare, publish/print, maintain, produce, and distribute to DHH distinct System design and management manuals, user manuals and quick reference guides, and any updates;
- Ensure the System user manuals contain information about, and instruction for, using applicable System functions and accessing applicable system data;
- Ensure when a System change is subject to DHH prior written approval, the CCN and or its contractor will submit revision to the appropriate manuals before implementing said System changes;
- Ensure all aforementioned manuals and reference guides be available in printed form and/or on-line; and
- Update the electronic version of these manuals immediately, and updates to printed versions will occur within ten (10) business days of the update taking effect.

System Function Reporting Requirements

The CCN shall provide systems-based capabilities, such as ad-hoc tools, that enable designated DHH, FI or other DHH authorized staff or contractors, and designated Louisiana Attorney General Office staff, on a secure and read-only basis, query access to data that can be used in ad hoc reports.

Electronic Messaging

The CCN shall provide a continuously available electronic mail communication link (e-mail system) to facilitate communication with DHH. This e-mail system shall be capable of attaching and sending documents created using software compatible with DHH's installed version of Microsoft Office and any subsequent upgrades as adopted. As needed, the CCN shall be able to communicate with DHH over a secure VPN. The CCN shall comply with national standards for submitting protected public health information (PHI) electronically and shall set up a secure emailing system that is password protected for both sending and receiving any personal health information.

Address Standardization

The CCN System shall utilize mailing address standards in accordance with the United States Postal Service.

Electronic Medical Records

At such time that DHH requires, the CCN shall participate and cooperate with DHH to implement, within a reasonable timeframe, a secure, web-accessible health record for members, such as Personal Health Record (PHR) or Electronic Health Records (EHR).

Statewide Health Information Exchange

At such time that DHH requires, the CCN shall participate in statewide efforts to incorporate all hospital, physician, and other provider information into a statewide health information exchange.

HIPAA-Based Formatting Standards

The System shall conform to the following HIPAA-compliant standards for information exchange. Batch transaction types include, but are not limited to, the following:

- ASC X12N 834 Benefit Enrollment and Maintenance;
- ASC X12N 835 Claims Payment Remittance Advice Transaction;
- ASC X12N 837I Institutional Claim/Encounter Transaction;
- ASC X12N 837P Professional Claim/Encounter Transaction;
- ASC X12N 278 Utilization Review Inquiry and Response; and
- ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products.

Transaction types are subject to change and the CCN shall comply with applicable federal and HIPAA standards and regulations as they occur.

Audit Requirements

The CCN shall ensure that their System facilitates the auditing of individual claims. Adequate audit trails shall be provided throughout the System. To facilitate claims auditing, the CCN shall ensure that the System follows, at a minimum, the guidelines and objectives of the American Institute of Certified Public Accountants (AICPA) Audit and Account Guide, *The Auditor's Study and Evaluation of Internal Control in EDP Systems.*

The CCN shall maintain and adhere to an internal EDP Policy and Procedures manual, available for DHH review upon request, which at a minimum shall contain and assure all accessible screens used throughout the system adhere to the same Graphical User Interface (GUI) standards, and that all programmers shall adhere to the highest industry standards for coding, testing, executing and documenting all system activities. The manual is subject to yearly audit, by both state and independent auditors.

- **State Audit**

  The CCN shall provide to state auditors (including legislative auditors), upon written request, files for any specified accounting period that a valid Provider Agreement exists in a file format or audit defined media, magnetic tapes, CD or other media compatible with DHH and/or state auditor's facilities. The CCN shall provide information necessary to assist the state auditor in processing or utilizing the files.

  If the auditor's findings point to discrepancies or errors, the CCN shall provide a written corrective action plan to DHH within ten (10) business days of receipt of the audit report.

  At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the state auditors. These findings shall be reviewed by DHH and integrated into the CCN's EDP manual.

- **Independent Audit**

  The CCN shall be required to contract with an independent firm, subject to the written approval of DHH, which has experience in conducting EDP and compliance audits in accordance with applicable federal and state auditing standards for applications comparable with the scope of the Provider Agreement's System application. The independent firm shall:

  - Perform limited scope EDP audits on an ongoing and annual basis using DHH's audit program specifications at the conclusion of the first

twelve (12) month operation period and each twelve (12) month period thereafter, while the Provider Agreement is in force with DHH and at the conclusion of the Provider Agreement; and

- Perform a comprehensive audit on an annual basis to determine the CCN's compliance with the obligations specified in the Provider Agreement and this ***Guide***.

The auditing firm shall deliver to the CCN and to DHH a report of findings and recommendations within thirty (30) calendar days of the close of each audit. The report shall be prepared in accordance with generally accepted auditing standards for EDP application reviews.

DHH shall use the findings and recommendations of each report as part of its monitoring process.

The CCN shall deliver to DHH a corrective action plan to address deficiencies identified during the audit within ten (10) business days of receipt of the audit report. At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the independent auditing firm. These findings are reviewed by DHH and shall become a part of the CCN's EDP manual.

Audits shall include a scope necessary to fully comply with AICPA Professional Standards for Reporting on the Processing of Transactions by Service Organizations (SAS-70 Report).

Systems Refresh Plan

The CCN shall provide to DHH an annual System Refresh Plan. The plan shall outline how Systems within the CCN's span of control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors.

The systems refresh plan shall also indicate how the CCN will insure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the System component.

Termination Transition Plan

The CCN shall develop and maintain a termination transition plan which outlines the procedures and timelines to ensure continuity of services in the event of Provider Agreement

termination. The plan shall be reviewed during Step 2 of the enrollment process. The plan must include procedures that shall, at a minimum, comply with the following stipulations:

- Upon completion of the agreement or if terminated earlier, all information, records, documents, reports, work sheets or any other pertinent materials related to the execution of this agreement, shall become the property of DHH;
- In the event of termination, or as requested, the CCN and its contractors shall transfer all data and non-proprietary systems to DHH within the agreed upon timeframe; and
- The termination plan must be adhered to within thirty (30) calendar days of written notification of termination, unless other appropriate timeframes have been mutually agreed upon by both the CCN and DHH.

LEFT BLANK INTENTIONALLY

SECTION 14 - CLAIMS MANAGEMENT

General Provisions

In accordance with the requirements setforth in the Coordinated Care Network Program, the CCN shall notify providers to file all claims directly to the CCN for services provided to CCN members. Claims submitted directly to DHH's FI for a CCN member will be delayed and/or denied.

It is the CCN's responsibility to inform and educate all providers involved in the provision of care, to adhere to the CCN and DHH claims processing process. The CCN shall make a good faith effort to disseminate materials and maintain a record of all educational materials. The CCN must accept submission of claims in either electronic or hard copy paper form.

The CCN shall specify the timeframe in which a provider has to submit a clean claim with the CCN. The CCN must accept and pre-process claims within two (2) business days of receipt. Preprocessed approved claims will be paid on a fee-for-service (FFS) basis by DHH. DHH shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or SCHIP program pursuant to Section 1128 or 1156 of the Social Security Act or is otherwise not in good standing with DHH.

CCN Responsibilities-Service Authorization

- The CCN shall maintain a claims management System that will:
    - Provide service authorization approval to providers utilizing a unique authorization number as defined in the ***CCN-S Systems Companion Guide;***
    - Confirm CCN membership as service authorization requests are submitted on the basis of the eligibility information provided by DHH;
    - Verify medical necessity as defined by DHH;
    - Identify date of receipt (the date the CCN receives the claim);
    - Provide on-line and phone based capabilities to providers for obtaining status information;
    - Obtain a submitter identification number from the FI prior to submitting claims;
    - Submit electronic claims received from providers to FI within two (2) business days of receipt;

- Submit paper claims to the FI in batch form within two (2) business days of receipt. The FI maintains claims billing information on the DHH Medicaid website: http://www.lamedicaid.com/provweb1/billing_information.

  The following link will provide various address information for submitting paper claims: http://www.lmmis.com/provweb1/ProviderTraining/packets/2006ProviderTraning/0133%20%202006%20Basic%20Services%20Training.pdf

FI Responsibilities-Service Authorization

- Ensure MMIS verifies that a service is a covered service and is eligible for payment;
- Perform system edits for valid dates of service, and assure that dates of services are valid dates such as not in the future or outside of a members eligibility span;
- Identify date of receipt; and
- Provide web-based claims status and inquiry capability.

FI Responsibilities-Prompt Payment

- FI shall adhere to prompt payment requirements established under the American Recovery and Reinvestment Act of 2009. This ensures that ninety percent (90%) of clean claims for payment of services delivered to a member are paid to the provider within thirty (30) calendar days of the receipt of such claims and process and if appropriate pay, within ninety (90) calendar days, ninety-nine percent (99%) of all provider claims for covered services delivered to a member. The thirty (30) calendar days starts the date of claims receipt by the FI. Therefore, it is extremely important that the CCN adhere to the two (2) business day rule established by DHH. Sanctions or liquidated damages may be applied to the CCN for non-compliance of this rule.
- If a claim is partially or totally denied on the basis the provider did not submit required information or documentation with the claim, then a remittance advice or other appropriate written or electronic notice shall specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the timeframe for claims processing.

Claim Formats

The System shall conform to HIPAA-compliant standards for information exchange. Transaction types are subject to change and the CCN shall comply with applicable federal and HIPAA standards and regulations as they occur.

The CCN shall require that providers comply at all times with standardized paper billing forms and formats, and all future updates for Professional claims (CMS 1500), Institutional claims (UB 04), and Louisiana's KM3 form for EPSDT/KidMed billing of paper claims. All electronic claims shall be submitted to DHH in the standard HIPAA transaction formats, specifically the ANSI X12N 837 Transaction formats (P - Professional, and I - Institutional). If service authorization was received, the unique authorization number must be submitted either on the paper claim or the electronic claim.

The CCN **shall not revise or modify** the standardized forms or formats.

The CCN shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with DHH. These shall include, but not be limited to, HIPAA based standards, federally required safeguard requirements including signature requirements described in the CMS State Medicaid Manual.

The CCN agrees that at such time that DHH presents recommendations concerning claims billing and processing that are consistent with industry norms, the CCN shall comply with said recommendations within ninety (90) calendar days from notice by DHH.

Service Authorization Disputes

- The CCN shall:
  - Have an internal claims dispute procedure that will be reviewed and approved by DHH, during Step 2 of the CCN Enrollment Process and upon any changes;
  - Create a peer-to-peer internal review process separate from the parties who made the original determination to review disputed authorizations;
  - Adhere to the grievances and appeals process outlined in **§9** of the Provider Agreement and **§11** of this ***Guide***; and
  - Systematically capture the status and resolution of all authorization disputes as well as all associated documentation.

For audit and verification purposes, the service authorization requests should be maintained.

Remittance Advices and Related Functions

- In conjunction with its payment cycles, the FI shall provide the CCN with:
  - An electronic status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment;
  - The status report shall contain appropriate explanatory remarks related to payment or denial of the claim;
  - Assist providers in reconciliation of claims; and
  - If the claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice shall specifically identify all such information and documentation.

Payment Cycles

The FI receives claims twenty-four (24) hours per day seven (7) days per week. Claims which are received on or before 10:00 a.m. each Thursday will be processed in that week's batch cycle, and the claim is adjudicated (paid/denied) on the subsequent Tuesday.

LEFT BLANK INTENTIONALLY

SECTION 15 - REIMBURSEMENT

CCN Reimbursement

The FI shall make payments to the CCN based on an established monthly enhanced primary care case management rate for each enrollee in the CCN, and share of savings, if any. The enhanced primary care case management rate schedule is provided in Appendix D in the Provider Agreement. Specific information is provided in **§2.0** of the Provider Agreement.

Provider Reimbursement

Enrollment in Louisiana Medicaid is mandatory. Standards for participation include, but are not limited to:

- Agreement to charge no more for services to eligible recipients than is charged on the average for similar services to others;
- Agreement to accept as payment in full the amounts established by the Medicaid and refusal to seek additional payment from the member for any unpaid portion of a bill;
- Agreement to maintain medical records (as are necessary) and any information regarding payments claimed by the provider for furnishing services; and
- Participation in electronic funds transfer (EFT) for the direct deposit of payments for Medicaid services.

Providers must submit clean claims to the CCN for pre-processing. The CCN has two (2) business days from date of receipt to pre-process the claims and then forward to the FI in the format (paper or electronic) in which they were received. Payment cycles are provided in Section 14 of this ***Guide***.

If the adjudicated claims result in a pay status, providers will be reimbursed for the services provided to the Medicaid member based on the type of service and the payment methodology associated on a fee-for-service basis. Providers are strongly encouraged to become familiar with Medicaid's policy, procedures, bulletins, State Plan and fee schedules located on the Louisiana Medicaid website www.lamedicaid.com.

Providers will be sent a paper remittance advice weekly (if they had claims adjudicated in that particular cycle) for financial audit of submitted claims. DHH's FI will assist providers with addressing pre-processed claims with denial errors for correction and resubmission to the CCN.

Claims submitted by providers directly to the FI will be delayed and/or denied.

Health-Based Risk Adjustment Methodology

Health-based risk adjustment is a method that accounts for variation in health risks among participating CCNs when determining CCN-S shared savings . Risk adjustment provides a mechanism to better align the shared savings per capita prepaid benchmark (PCPB) to the expected costs based on the health risk of the enrolled population.

The Adjusted Clinical Groups (ACGs) developed by Johns Hopkins University will initially be used to assess the health risk of each Medicaid/CHIP member and calculate the relative health risk of each CCN.

Using diagnoses reported on FFS claims along with age and gender, the ACG model assigns members into approximately one hundred (100) mutually exclusive groups or risk categories with a similar level of expected resource utilization. For each risk category, the cost weight or relative health risk score dentoing the average costs of members relative to the overall population will initially be calculated using historical Louisiana specific experience from the fee-for-service Medicaid population.

The shared savings PCPB will be risk-adjusted by assessing the relative health risk of CCN members. The health risk will then be measured at the CCN level and will be used to adjust the universal PCPBs to arrive at the CCN-specific risk-adjusted PCPB. The risk-adjusted PCPB, in turn, will be used to determine the shared savings between the CCN and DHH. This will be accomplished by comparing the CCN-specific PCPB (adjusted to reflect the health risk of member enrollment) with the actual FFS medical costs for the measurement period.

Risk adjustment will begin three (3) months after initial program implementation. The PCPB for the initial three (3) months will be based entirely on the universal PMPM values. Starting in the fourth (4th) month of implementation in a geographic area, PCPBs will be risk-adjusted to applicable rate cells.

Assessment of individual member risk scores will be based on the most recent twelve months of complete fee-for-service claims data. The health risk of the members and the CCN will be updated on a semi-annual basis to reflect changes in risk over time.

LEFT BLANK INTENTIONALLY

SECTION 16 - FINANCIAL INFORMATION

Federal Financial Participation

The CCN and its contractor agrees to maintain supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state requirements, and are sufficient to ensure the accuracy and validity of CCN invoices. Such documents, including all original claim forms, shall be maintained and retained by the CCN and or its contractors for a period of six (6) years after the Provider Agreement expiration date or until the resolution of all litigation, claim, financial management review or audit pertaining to the Provider Agreement, whichever is longer. There shall be no restrictions on the right of the state and federal government to conduct inspections and audits as deemed necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs.

Access to Records, Books, and Documents

Upon reasonable notice, CCN and its contractors shall provide the officials and entities identified in this Section with prompt, reasonable, and adequate access to any records, books, documents, and papers that are related to the performance of the scope of work.

The CCN and its contractors shall provide access described in this Section upon DHH's request for the purposes of examination, audit, investigation, Provider Agreement administration; making of copies, excerpts, or transcripts or any other purposes as deemed necessary by DHH.

Access shall be provided to the following officials and/or entities:

- The United States Department of Health and Human Services or its designee;
- The Comptroller General of the United States or its designee;
- DHH or its designee;
- The Office of Inspector General;
- Any independent verification and validation contractor or quality assurance contractor acting on behalf of DHH;
- The Louisiana Legislative Auditor or its designee;
- A state or federal law enforcement agency;
- A special or general investigating committee of the Louisiana Legislature or its designee; and
- Any other state or federal entity identified by DHH, or any other entity engaged by DHH.

The CCN agrees to provide the access described wherever the CCN maintains such books, records, and supporting documentation. The CCN further agrees to provide such access in

reasonable comfort and to provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described in this Section. The CCN shall require its contractors to provide comparable access and accommodations.

Audit of Services, Deliverables, and Inspections

The CCN and its contractors shall provide DHH and its designees, which may include auditors and inspectors, with access to CCN service locations, facilities, or installations; and software including any and all files produced by this software and equipment.

Access described in this Section shall be for the purpose of examining, auditing, or investigating:

- Capacity to bear the risk of potential financial losses;
- Services and deliverables provided;
- Determination of the amounts payable under the Provider Agreement;
- Detection of fraud, waste and/or abuse; or
- Other purposes DHH deems necessary to perform its regulatory function and/or enforce the provisions of the Provider Agreement.

The CCN shall provide any assistance that such auditors and inspectors reasonably may require to complete such audits or inspections.

If, as a result of an audit or review of payments made to the CCN, DHH discovers a payment error or overcharge, DHH shall notify the CCN of such error or overcharge. DHH shall be entitled to recover such funds as an offset to future payments to the CCN, or to collect such funds directly from the CCN. The CCN shall return funds owed to Department within thirty (30) days after receiving notice of the error or overcharge, or interest shall accrue on the amount due. DHH shall calculate interest at the Treasury's Median Rate (resulting from the Treasury's auction of 13-week bills) for the week in which liability is assessed. In the event that an audit reveals that errors in reporting by the CCN have resulted in errors in payments to the CCN, the CCN shall indemnify DHH for any losses resulting from such errors, including the cost of audit.

Louisiana Legislative Auditor's Audit

The CCN understands that acceptance of funds under the Provider Agreement with DHH acts as acceptance of the authority of the Louisiana Legislative Auditor, or any successor agency, to conduct an investigation in connection with those funds. The CCN further agrees to cooperate fully with the Louisiana Legislative Auditor or its successor conducting the

audit or investigation, including providing all records requested. The CCN shall ensure that this clause concerning the authority to audit funds received indirectly by contractors through the CCN and the requirement to cooperate is included in any contract it awards, and in any third party agreements described in §19.0 – *Additional Terms and Conditions* of this ***Guide***.

The CCN shall ensure compliance with or outline corrective action plans for of any finding of noncompliance based on law, regulation, audit requirement, or generally accepted accounting principles or any other deficiency contained in any audit, review, or inspection conducted. This action shall include the CCN's delivery to DHH, for approval, a Corrective Action Plan that addresses deficiencies identified in any audit(s), review(s), or inspection(s) within thirty (30) calendar days of the close of the audit(s), review(s), or inspection(s).

CCNs shall bear the expense of compliance with any finding of noncompliance under this Section that is:

- Required by Louisiana or federal law, regulation, rule or other audit requirement relating to the CCN's business;
- Performed by the CCN as part of the Services or Deliverables; or
- Necessary due to the CCN's noncompliance with any law, regulation, rule or audit requirement imposed on the CCN.

Upon DHH request, the CCN shall provide a copy of those portions of the CCN's and its contractors' internal audit reports relating to the services and deliverables provided to DHH under the Provider Agreement.

Report Transactions

- Financial Reports

  The CCN shall submit to the Agency annual audited financial statements and four quarterly unaudited financial statements. DHH, in certain circumstances and at its discretion, may also require monthly financial reporting.

  The CCN shall submit financial statements and reports that are specific to the operations of the CCN rather than to a parent or umbrella organization.

  The audited financial statements are due no later than six (6) months after the end of each Provider Agreement year.

  The CCN shall submit the quarterly unaudited financial statements no later than 60 days after each calendar quarter and shall use generally accepted accounting principles in preparing the unaudited quarterly financial statements, which shall include but not limited to, the following:

- Balance Sheet;
- Income Statement;
- Statement of Cash Flows;
- Statement of Retained Earnings;
- Notes and/or Footnotes to the Financial Statements

Monthly reporting, when required by DHH, is due within thirty (30) days of each month end.

Insolvency

- If the CCN becomes insolvent, Medicaid/CHIP members shall not be held liable for the following:
  - The CCN's debts in the event of insolvency;
  - Covered services provided to the member, for which the state does not pay the CCN;
  - Covered services provided to the member, for which DHH or the CCN does not pay the individual or health care provider that furnishes the services under a contractual referral or other arrangement; and/or
  - Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the CCN provided the services directly.

Financial Solvency

- Protection Against Liability

  The CCN shall not hold members liable for the following:
  - For debts of the CCN, in the event of the CCN's insolvency;
  - For payment of covered services provided by the CCN if the CCN has not received payment from DHH for the covered services, or if the provider, under the contract or other arrangement with the CCN fails to receive payment from DHH or the CCN; and/or

- For payments to a provider, including referral providers, that furnished covered services under a contract, or other arrangement with the CCN, that are in excess of the amount that normally would be paid by the member if the covered services had been received directly from the CCN.

Other Requirements

- **Solvency**

  The CCN shall, at all times, maintain capitalization and surplus requirements set forth in the Provider Agreement.

- **Corporate Financial Condition**

  - DHH shall review the corporate financial condition during the CCN Enrollment Process, at each of the three (3) one-year extensions, and upon any suspicion or findings of possible financial inadequacy for performance of the Provider Agreement. The CCN's ability to demonstrate adequate financial resources for performance of the Provider Agreement or the ability to obtain such resources as required during performance under the Provider Agreement shall be given special emphasis.

  - During Step 2 of the CCN Enrollment Process, the CCN shall include for each of the last three (3) years, copies of financial statements, preferably audited, including at least a balance sheet and profit and loss statement, or other appropriate documentation which would demonstrate to DHH the CCN's financial resources sufficient to conduct the project.

Charitable Donations

DHH followes the federal guidelines for allowable and non-allowable costs as outlined in OMB Circular A-122. This applies to any charitable contribution, donation or support from the CCN to an organization or entity in the form of cash, property or services rendered from CCN program funds. In addition, the CCN:

- May not make charitable donations or contributions from CCN program funds.

- Is allowed to make charitable contributions or donations from its general revenue, earned income funds, or other corporate income funds without DHH approval, as long as the CCN does not report such charitable contributions or donations as an Allowable Expense.

SECTION 17- FRAUD, ABUSE AND WASTE PREVENTION

General Requirements

The CCN shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP programs. The CCN shall cooperate and assist the state and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. At any time during normal business hours, 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 the 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 the Provider Agreement and this ***Guide*** and any other applicable rules. The CCN 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 the Provider Agreement. The CCN shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

CCN's employees and its contractors and their employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.

DHH shall monitor enrollment and termination practices and ensure proper implementation of the CCN's grievance procedures. DHH and its designee shall have access to all information related to complaints and grievances 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, the Provider Agreement, and DHH policy.

Fraud and Abuse Compliance Plan

The CCN shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory compliance plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in the administration and delivery of services. The CCN shall provide a copy of the compliance

plan during the CCN Enrollment Process for approval and the CCN shall submit to DHH for approval any updates or modifications at least thirty (30) days in advance of making them effective. DHH may require that the CCN modify its compliance plan at its sole discretion.

The CCN compliance program and fraud, abuse, and waste prevention policies shall comply with 42 CFR §438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' ***Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks***) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments. The CCN compliance program shall incorporate the policy and procedures specified in *Appendix Q- Coordination of Coordinated Care Network Fraud and Abuse Complaints and Referrals*.

The CCN shall designate a compliance officer and compliance committee that have the responsibility and authority for carrying out the provisions of the compliance program. These individuals shall be accountable to the CCN's board of directors and shall be directly answerable to the Executive Director or to the board of directors and senior management. The CCN shall have an adequately staffed Medicaid compliance office with oversight by the compliance officer.

At a minimum, the compliance plan shall incorporate the following:

- Written policies, procedures, and standards of conduct that articulate CCN's commitment to comply with all applicable Federal and State standards;

- Effective lines of communication between the compliance officer and the CCN's employees, providers and contractors enforced through well-publicized disciplinary guidelines;

- Procedures for ongoing monitoring and auditing of CCN systems, including, but not limited to, claims processing, billing and financial operations, enrollment functions, member services, continuous quality improvement activities, and provider activities;

- Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the compliance officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel;

- Provisions for internal monitoring and auditing reported fraud, abuse, and waste in accordance with 42 CFR §438.608(b)(4-6);

- Protections to ensure that no individual who reports plan violations or suspected fraud, abuse, or waste is retaliated against and that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible;

- Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the Provider Agreement in accordance with 42 CFR §438.608(b)(7);

- Well-publicized disciplinary procedures that shall apply to employees who violate the CCN compliance program;

- Effective education for the compliance officer, managers, employees, providers and members to ensure that they know and understand the provisions of CCN's compliance plan; and

- Procedures for timely consistent exchange of information and collaboration with the DHH Program Integrity Unit.

Prohibited Affiliations

The CCN is prohibited from knowingly having a relationship with:

- 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

- An individual who is an affiliate, as defined in the federal acquisition regulations, of a person described above.

The prohibited relationships are:

- A director, officer, or partner of the CCN;

- A person with beneficial ownership of 5 percent or more of the CCN's equity; or

- A person with an employment, consulting or other arrangement with the CCN for the provision of items and services which are significant and material to the CCN's obligations.

The CCN shall notify DHH within three (3) days of the time it receives notice that action is being taken against the CCN or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the CCN or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.

Excluded Providers

Federal Financial Payment (FFP) is not available for amounts expended for providers excluded by Medicare, Medicaid, or CHIP except for emergency services as specified in Section 1128 or 1156 of the Social Security Act.

Reporting

In accordance with 42 CFR §455.1(a)(1) and §455.17, the CCN shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect information, relative to the Provider Agreement, to the state's Office of Inspector General Medicaid Fraud Control Unit (MFCU), and DHH within five (5) business days of discovery, taking prompt corrective actions and cooperating with DHH in its investigation of the matter(s). Additionally, the CCN shall promptly report to DHH, within three (3) business days, when it is discovered that any CCN employees, network provider, contractor, or contractor's employees have been excluded, suspended, or debarred from any state or federal healthcare benefit program. DHH will also alert the CCN's compliance coordinator via written notice of any provider under surveillance.

The CCN shall meet with DHH and the MFCU periodically, at DHH's request, to discuss fraud, abuse, neglect and overpayment issues. For purposes of this Section, the CCN's compliance officer shall be the point of contact for the CCN.

The CCN, through its compliance officer, has an affirmative duty to report all activities on a quarterly basis to DHH. If fraud, abuse, waste, neglect and overpayment issues are suspected, the CCN compliance officer shall report it to DHH immediately upon discovery. Reports shall include, but are not limited to:

- Number of complaints of fraud, abuse, waste, neglect and overpayments made to the CCN that warrant preliminary investigation; and
- Number of complaints reported to the Compliance Officer.

For each complaint that warrants investigation, the CCN shall provide DHH, at a minimum, the following:

- Name and ID number;
- Source of complaint;

- Type of provider;
- Nature of complaint;
- Approximate dollars involved if applicable; and
- Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.

Service Verification

The CCN shall have a method to verify that services for which reimbursement was made was provided to members.

State Conflict of Interest Safeguards

The CCN may not enter into a contract with a state agency unless conflict of interest safeguards at least equal to federal safeguards (41 USC 423, section 27) are in place.

Whistleblower Protections

The CCN shall ensure that no individual who reports compliance plan violations or suspected fraud and abuse is retaliated against by anyone who is employed by or contracts with CCNs. Anyone who believes that he or she has been retaliated against may report this violation to the Louisiana Medicaid Office of Program Integrity and/or the U.S. Office of Inspector General.

Medical Records

The CCN shall have policies and procedures to maintain, or require CCN providers and contractors to maintain, an individual medical record for each member.

- The CCN shall ensure the medical record is:
  - Accurate and legible;
  - Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all members evaluated or treated, and is accessible for review and audit; and
  - Readily available for review and provides medical and other clinical data required for Quality and Utilization Management review.
- The CCN shall ensure the medical record includes, minimally, the following:

- Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);

- Primary language spoken by the member and any translation needs of the member;

- Services provided through the CCN, date of service, service site, and name of service provider;

- Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the CCN;

- Referrals including follow-up and outcome of referrals;

- Documentation of emergency and/or after-hours encounters and follow-up;

- Signed and dated consent forms (as applicable);

- Documentation of immunization status;

- Documentation of advance directives, as appropriate;

- Documentation of each visit must include:

  - Date and begin and end times of service;
  - Chief complaint or purpose of the visit;;
  - Diagnoses or medical impression;
  - Objective findings;
  - Patient assessment findings;
  - Studies ordered and results of those studies (e.g. laboratory, x-ray, EKG);
  - Medications prescribed;
  - Health education provided;
  - Name and credentials of the provider rendering services (e.g. MD, DO, OD) and the signature or initials of the provider; and
  - Initials of providers must be identified with correlating signatures.

- Documentation of EPSDT requirements including but not limited to:

  - Comprehensive health history;
  - Developmental history;
  - Unclothed physical exam;

- Vision, hearing and dental screening;
- Appropriate immunizations;
- Appropriate lab testing including mandatory lead screening; and
- Health education and anticipatory guidance.

The CCN is required to provide one (1) free copy of any part of member's record upon member's request.

All documentation and/or records maintained by the CCN or any and all of its network providers shall be maintained for at least six (6) years after the last good, service or supply has been provided to a member or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.

LEFT BLANK INTENTIONALLY

SECTION 18 – SANCTIONS AND DISPUTE RESOLUTION

General Provisions

Upon receipt by DHH of evidence of noncompliance by the CCN with any of the provisions of the Provider Agreement, DHH reserves the right to suspend or limit enrollment or reduce monthly enhanced primary care case management fee payments until the condition of noncompliance has been remedied. Such sanctions will not be applied until after written notification to the CCN. DHH reserves the right to resort to other remedies provided by law or as provided herein, and to terminate the Provider Agreement.

Payments made by a CCN are subject to review by DHH to ensure the quality, quantity and need for services. Administrative sanctions may be imposed against any CCN which does not meet the guidelines as listed in the following subsection. Administrative sanction means any administrative action applied by DHH to a CCN which is designed to remedy an inefficient and/or illegal practice which is in noncompliance with the Louisiana Medicaid Coordinated Care Program policies and procedures, statutes and regulations, quality of care standards, or noncompliance with the requirements of the Provider Agreement.

Administrative Actions

DHH shall notify the CCN through a written *Notice of Action* when it is determined the CCN is deficient or non-compliant with requirements of the Provider Agreement. Administrative actions exclude intermediate actions and termination. Administrative actions include, but are not limited to:

- A warning through written notice or consultation;
- Education requirement regarding Program Policies and Billing Procedures;
    - CCN may be required by DHH to participate in a provider education program as a condition of continued participation. CCN education programs will include a letter of warning or clarification on the use and format of provider manuals; instruction on the use of procedure codes; review of key provisions of the Medicaid Program; instruction on reimbursement rates; and instructions on how to inquire about coding or billing problems; and quality/medical issues;
- Review of Prior authorization implementation processes;
- Referral to the appropriate State certification agency (Department of Insurance) for investigation;
- Referral for review by appropriate professional organizations. (e.g. Louisiana Medical Society, Certified Public Accountants);

- Referral to the Office of the Attorney General for fraud investigation;
- Require that the CCN secure an additional performance bond in an amount up to six (3) months of enhanced primary care case management fee payments; and/or
- Require submission of a corrective action plan.

Monetary Penalties

CNN shall be responsible for monetary penalties as outlined in the Provider Agreement.

The State has the right to recovery of any amounts overpaid as the result of deceptive practices by the CCN and/or its contractors, and may consider trebled damages, civil penalties, and/or other remedial measures designed to make the program whole.

Intermediate Sanctions

CCN shall be responsible for Intermediate Sanctions as outlined in the Provider Agreement and this ***Guide.***

- **Suspension of Enrollment**

  If DHH determines that the CCN is out of compliance with the Provider Agreement, DHH may instruct the Enrollment Broker to suspend the CCN's enrollment of new members under the Provider Agreement after notification by DHH. DHH, when exercising this option, will notify the CCN in writing of its intent to suspend new enrollment prior to the beginning of the suspension period. The suspension period may be for any length of time specified by DHH. DHH will submit a *Notice of Suspension of Enrollment* no less than five (5) calendar days previous to initiation of suspension. The Louisiana Medicaid Director may require the provider to correct any deficiencies which served as the basis for the suspension as a condition of reinstatement of enrollment activities.

- **Withhold Payment**

  - DHH may suspend or withhold a portion of PMPM payments on the following grounds:

    - If DHH determines the CCN failed to provide any portion of enhanced primary care case management services. DHH may direct the CCN to provide such service or withhold a portion of the CCN's PMPM payments for the following month or subsequent months with such portion withheld to be equal to

the amount of money DHH must pay to provide such services. DHH shall submit a Notice of Withhold no less than 5 (five) days previous to the initiation of the withhold.

i. When DHH withholds payments under this Section, DHH must submit to the CCN a list of the members for whom payments are being withheld and payments DHH must make to provide services.

- Failure to staff the key positions(s)
- Failure to remit monetary penalties as required in this Section.

o In any case where DHH intends to withhold PMPM payments or recover monetary penalties through the exercise of other legal processes, the following procedures shall be used:

- DHH shall notify the CCN through a *Notice of Action* of the CCN's failure to perform required services under the Provider Agreement.
- DHH will provide the CCN with a written statement itemizing the damage costs for which it intends to require compensation prior to withholding any PMPM payment. DHH shall submit a Notice of Withhold at a minimum of five (5) days prior to the initiation of the withhold.

o DHH may, by written notice, waive or delay the imposition of any and all monetary penalties if it determines that that the events causing the CCN to be liable for any monetary penaliteswere beyond the control of the CCN. DHH shall be the sole determiner of such delays and/or waivers and shall exercise this authority with reasonableness and in the best interest of the State.

o In any case under the Provider Agreement where DHH has the authority to withhold PMPM payments, DHH also has the authority to use all other legal processes for the recovery of monetary penalties.

- **Recovery of Monies**

DHH shall reduce the PMPM payment to the CCN for the amount of an identified monetary sanction, in the month following the written *Notice of Action*, unless otherwise indicated in the *Notice of Action*. The CCN may elect to pay the monetary sanction amount in full or through reduction in PMPM

payments made by DHH. If the monetary sanction exceeds the PMPM payments due from DHH, the CCN shall be required to make cash payments for the amount in excess within fifteen (15) days of written *Notice of Action* of the amount due.

In any case where DHH has the authority to withhold PMPM payments, DHH also has the authority to use all other legal processes for the recovery of monetary penalties.

Corrective Action Plans (CAP)

The CCN shall comply with all requirements and performance standards set forth in the Provider Agreement and this ***Guide***. In the event DHH identifies a violation or other non-compliance, the CCN may be required to submit a corrective action plan within ten (10) calendar days of the date of receipt of notification of the violation or non-compliance from DHH, unless otherwise specified in the Notice of Action.

DHH shall determine whether the corrective action plan is approved. If the CAP is not approved, the CCN shall submit, within ten (10) business days or as specified in the Notice of Action, a new corrective action plan addressing the concerns identified by DHH.

Upon receiving approval of the CAP, the CCN shall implement the action steps set forth in the CAP within the time frames specified by DHH.

Imposition and Extent of Sanctions

Imposition of a Sanction(s)

The decision as to the sanction(s) to be applied shall be at the discretion of DHH, except as provided in *Assessment of Civil Monetary Penalties* subsection of this Section and federal Public Law 95-142, Section 7.

The following factors shall be considered in determining sanction(s) to be imposed:

- Seriousness of the offense(s);
- Patient quality of care issues;
- Failure to perform administrative functions;
- Extent of violations; history of prior violations; prior imposition of sanctions;
- Prior provision of provider education; provider willingness to obey program rules;
- Whether a lesser sanction will be sufficient to remedy the problem; and
- Actions taken or recommended by peer review groups or licensing boards.

Scope of Sanctions

A sanction may be applied to all known affiliates of a CCN, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the CCN is affiliated where such conduct was accomplished within the course of his official duty or was effectuated by him with the knowledge or approval of such person.

Suspension from participation of any CCN shall preclude such CCN from receiving enhanced primary care case management fee payments for any services or supplies provided under the Provider Agreement except for those services or supplies provided prior to the suspension or termination.

CCN shall not submit pre-processed claims to the agency or its fiscal intermediary for any services or supplies provided by a person within such organization who has been suspended or terminated from participation in the Medicaid, Medicare, or CHIP Program except for those services or supplies provided prior to the suspension or termination.

When the requirements that the CCN offer PCP services during regular business hours and one evening or one weekend per month to address non-emergency issues encountered by members are violated by a CCN, DHH may suspend enrollment and/or apply monetary penalties.

Misconduct for Which Sanctions May Be Imposed

DHH may impose sanctions against any CCN if the agency finds, including but not limited to, any of the following non exclusive actions/occurrences:

- CCN is not properly licensed or qualified, or such CCN's professional license, certificate or other authorization has not been renewed or has been revoked, suspended, or otherwise terminated;

- CCN has engaged in a course of conduct or has performed an act for which official sanction has been applied by the certifying authority, professional peer group, or peer review board or organization or continues such conduct following notification by the licensing or reviewing body that said conduct should cease;

- CCN has failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from DHH;

- CCN has been excluded from participation in Medicare because of fraudulent or abusive practices pursuant to Public Law 95-142;

- CCN, its owners, officers or directors have been convicted of a criminal offense relating to performance of the Provider Agreement with DHH or of fraudulent billing practices or of negligent practice resulting in death or injury to the CCN's member;

- CCN has presented, or has caused to be presented, any false or fraudulent claim for services or has submitted or has caused to be submitted false information to be furnished to the State or the Secretary of federal Department of Health and Human Services;

- CCN has engaged in a practice of charging and accepting payment (in whole or part) from members for enhanced primary care case management services for which a PMPMpayment was made by DHH;

- CCN has rebated or accepted a fee or portion of fee or charge for a patient referral;

- CCN has failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments;

- CCN has failed to keep or make available for inspection, audit or copying, such records regarding payments claimed for providing services;

- CCN has failed to furnish any information requested by DHH regarding payments for providing goods or services;

- CCN has made, or caused to be made, any false statement or representation of a material fact in connection with the administration of the Provider Agreement;

- CCN has furnished goods or services to a member which are:

    - Insufficient for his or her needs,

    - Harmful to the recipient, or

    - Of grossly inferior quality;

All such determinations are at the sole discretion of DHH and shall be based on competent medical judgment and evaluation;

- Filing of a false statement that does not result in an immediate or direct reimbursemente.g., overstating performance measures results);

- The CCN and any of its contractors:
  - Directly or indirectly gives, offers, or promises anything to a health care official, or offers or promises a health care official to give anything of value to another person, with intent:
    - To influence or reward any acts or decisions of any health care official exercising any authority in any state funded CCN;
    - To influence such official to commit or aid in the commission or conspire to allow any fraud in a state funded CCN;
    - To induce such an official to engage in any conduct in violation of the lawful duty of such official; or
    - Being a health care official, directly or indirectly demands, solicits, receives, accepts or agrees to accept anything of value personally or for any other person or entity, the giving of which would violate the paragraph above;
- Engaging in any unfair or deceptive marketing practices in connection with proposing, offering, selling, soliciting, and providing any health care services for any CCN. Unfair or deceptive marketing practices shall include, but is not limited to:
  - False, misleading oral or written statement, visual description, advertisement, or other representation of any kind with has the capacity, tendency, or effect of deceiving or misleading CCN potential enrollees or enrollees with respect to any health care services, CCN or health care provider or the DHH Coordinated Care Program;
  - Representation that a CCN or network provider offers any service, benefit, access to care, or choice which it does not have;
  - Representation that a CCN or health care provider has any status, certification, qualification, sponsorship, affiliation, or licensure which it does not have;
  - Failure to state a material fact if the failure deceives or tends to deceive;
  - Offering any kickback, bribe, award, or benefit to any Medicaid/ CHIP eligible as an inducement to select, or to refrain from selecting any health care service, CCN, or health care provider, unless the benefit

offered is medically necessary health care;

- Use of the Medicaid/CHIP eligible or other information which is confidential, privileged, or which cannot be disclosed to or obtained by the user without violating a state or federal confidentiality law, including:
  - Medical records information and
  - Information which identifies the recipient or any member of his or her group as a recipient of any government sponsored or mandated health coverage program
- Use of any device or artifice in advertising a CCN or soliciting a Medicaid/CHIP eligible which misrepresents the solicitor's profession, status, affiliation, or mission.

Federal Sanctions

Section 1903 (m) (5) (A) and (B) of the Social Security Act vests the Secretary of the Department of Health and Human Services with the authority to deny Medicaid payments to a CCN for members who enroll after the date on which the CCN has been found to have committed one of the violations set forth in the Provider Agreement. State payments for members of the CCN are automatically denied whenever, and for as long as, federal payment for such members have been denied as a result of the commission of such violations. The following violations can trigger denial of payment pursuant to section 1903 (m) (5) of the Social Security Act:

- Substantial failure to provide required medically necessary items or services when the failure had adversely affected (or has substantial likelihood of adversely affecting) a member,
- Discrimination among Medicaid enrollees with respect to enrollment, re-enrollment, or disenrollment on the basis of the Medicaid elibibles' health status or requirements for health care services, or
- Misrepresentation or falsification of Provider Agreement or other required submissions.

Remedial Actions

DHH may pursue all remedial actions with the CCN that are taken with fee-for-service providers. DHH is committed to working with the CCN and the CCN providers to correct problems. Failure to correct problems will result in recoupment of funds from the CCN.

Maintaining Financial and Operational Capacity

The CCN must maintain the financial and operational capacity to fulfill the obligations of the Provider Agreement. If the CCN fails to maintain such capacity, DHH may withhold partial payment to the CCN. Partial payments may be withheld until DHH is assured that the CCN has no outstanding financial obligations resulting from the Provider Agreement.

Notice of Action

DHH shall notify a CCN the intent to impose sanctions through issuance of a *Notice of Action* specifying the nature of and grounds for the sanction, except that notification is discretionary when the sanctions involved are prepayment review or referral for an investigation or review.

- The *Notice of Action* shall set forth:
  - The nature of the discrepancies or violations;
  - Notification of further actions to be taken or sanctions to be imposed by DHH;
  - Notification of any actions required of the CCN; and
  - Notification of the CCN's opportunity to employ the dispute resolcution process as described in the Provider Agreement.

Right to an Informal Meeting

If the CCN wants to request an informal meeting with the Medicaid Deputy Director for MCCS, it must do so within fifteen (15) calendar days of the date of the *Notice of Action*. The request for informal review must be made to DHH in writing. A meeting will be arranged within fourteen (14) business days of the receipt by DHH of the request. The informal meeting is designed to provide an opportunity for:

- The CCN to informally review the nature and grounds for the sanctions;
- DHH to offer alternatives based on corrections or clarifications, if any; and
- The CCN to evaluate the necessity for seeking a dispute resolution conference.

During this informal meeting, the CCN will be afforded the opportunity to talk with the Medicaid Deputy Director and other DHH personnel involved in the situation, to review pertinent documents on which the alleged non compliance and/or violation is based, to ask questions, to seek clarification, and to provide additional information.

The Medicaid Deputy Director shall inform the CCN in writing through a *Notice of Results of the Informal Meeting (Notice of Results)* within fourteen (14) calendar days of the conference. The *Notice of Results* shall inform the CCN as to whether he/she will cancel, modify, or uphold the action proposed in the *Notice of Action*. The CCN has the right to request a dispute resolution conference within thirty (30) calendar days of the date of written notice of the results of the informal meeting.

Right to Request Dispute Resolution Conference

Within thirty (30) calendar days after the date of *Notice of Action*, or the date of *Notice of Results,* the CCN may request a dispute resolution conference. Such request must be in writing to the Medicaid Director of DHH. The request must contain a statement and be accompanied by supporting documents setting forth those asserted violations and discrepancies which the CCN contends are in compliance with DHH's regulations, polices, ***Guide***s, and/ or the Provider Agreement and all addenda, and amendments.

Unless a timely and proper request is received, the findings of DHH shall be considered a final and binding administrative determination and the CCN forfeits its right to request a dispute resolution conference.

Termination of Provider Agreement

- **Termination**

  DHH may terminate a CCN's Provider Agreement and enroll that entity's members in other CCNs, or provide Medicaid benefits through other options included in the state plan, if DHH determines that the CCN has failed to:

  - Carry out the substantive terms of its contracts, or
  - Meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Act.

- **Pre-Termination Hearing and Procedures**

  Before terminating a CCN Provider Agreement under 42 CFR §438.708, DHH shall hold a a pre-termination hearing. DHH shall:

  - Give the CCN written notice of its intent to terminate, the reason for termination, and the time and place of pre-termination meeting.
  - Give the entity (after the hearing) written notice (*Notice of Results*) of the decision affirming or reversing the proposed termination of the Provider Agreement, and for an affirming decision, the effective date of termination; and

- For an affirming decision, give members of the CCN notice of the termination and information, consistent with 42 CFR §438.10, on their options for receiving Medicaid services following the effective date of termination.

- **Disenrollment During Termination Hearing Process**

  After DHH notifies a CCN that it intends to terminate the Provider Agreement, the state may do the following:

  - Give the entity's members written notice of DHH's intent to terminate the Provider Agreement; or

  - Allow members to disenroll immediately without cause.

The CCN shall comply with all requirements specified in the Provider Agreement, **§13.3.5.8-** *CCN Requirements Prior to Termination for Cause*.

Attorney Fees

In the event the State should prevail in any legal action arising out of the performance or non-performance of the Provider Agreement, the CCN shall pay, in addition to any monetary penalties, all expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

LEFT BLANK INTENTIONALLY

SECTION 19 – ADDITIONAL TERM AND CONDITION REQUIREMENTS

Additional Requirements for CCN Contracts with Other Parties

The CCN shall be responsible for all work performed under the Provider Agreement, but may enter into contracts for the performance of work required under the Provider Agreement. The CCN shall not contract with any other party for furnishing any of the deliverables and/or professional services required by the Provider Agreement without the express prior written approval of DHH.

The CCN is accountable for deliverables provided by any contractor to whom it delegates services contained in the Provider Agreement. Before any delegation, the CCN shall evaluate the prospective contractor's ability to perform the activities to be delegated.

If the CCN identifies deficiencies or areas needing improvement, the CCN shall ensure that the contractor takes corrective action.

If the CCN knowingly executes a contract with a provider with the intent of allowing or permitting the contractor to implement barriers to care (i.e. the terms of the contract are more restrictive than the Provider Agreement), the CCN shall be in default of its Provider Agreement.

If the CCN becomes aware that a contractor has failed to comply with the terms of their contract and does not take corrective action within thirty (30) calendar days, the CCN shall be in default of the CCN's Provider Agreement with DHH and shall be subject to sanctions until compliance is met.

All contracts must comply with 42 CFR §438.230, 42 CFR §455.104, 42 CFR §455.105 and 42 CFR §455.106. All contracts and amendments executed by the CCN shall meet the requirements required in **§5.0** – *Contract Requirements* of the Provider Agreement and **§9** – *General CCN and Network Provider Responsiblities* of this ***Guide*** and the following requirements:

- If a contractor was involuntarily terminated from the Louisiana Medicaid Program other than for purposes of inactivity, that entity is not considered an eligible contractor;

- Contractors are subject to background checks. The CCN shall consider the nature of work a contractor or agent will perform in determining the level and scope of the background checks;

- The CCN shall document compliance certification (business-to-business) testing of transaction compliance with HIPAA for any contractor receiving member data; and

- No contract that the CCN enters into with respect to performance under the Provider Agreement shall, in any way, relieve the CCN of any responsibility for the performance duties under the Provider Agreement. The CCN shall assure that all tasks related to the contract are performed in accordance with the terms of the Provider Agreement and shall provide DHH with the monitoring schedule at the Readiness Review and annually by December 1st of each Provider Agreement year. The CCN shall identify in its contracts any aspect of service that may be further contracted by the contractor.

All model and executed contracts and amendments used by the CCN under the Provider Agreement shall be in writing, signed and dated by the CCN and the contractor and meet the following requirements:

- Identification of conditions and method of payment:
  - Provide for prompt submission of information (e.g., pre-processed claims, prior authorization files) to the FI needed to make payment;
  - Provide for full disclosure of the method and amount of compensation or other consideration to be received from the CCN; and
  - Require an adequate record system be maintained for recording services, charges, dates and all other commonly accepted information elements for services rendered to the CCN.
- Provisions for monitoring and inspections shall include:
  - Provide that DHH and DHHS may evaluate through inspection or other means the quality, appropriateness and timeliness of services performed;
  - Provide for the inspections of any records pertinent to the Provider Agreement by DHH and DHHS;
  - Require that records be maintained as specified in the Provider Agreement; and
  - Provide for monitoring of services rendered to CCN members through the contractor.
- Specification of functions of the CCN Contractor:
  - Identify the population covered by the contract;

- Provide for submission of all reports and clinical information required by the CCN; and
- Provide for the participation in any internal and external quality improvement, utilization review, peer review, and grievance procedures established by the CCN.

- Protective Clauses
  - Require safeguarding of information about members according to 42 CFR, Part §438.224;
  - Require compliance with HIPAA and ARRA privacy and security provisions;
  - Require an exculpatory clause, which survives contract termination, including breach of contract due to insolvency, which assures that Medicaid/CHIP members or DHH will not be held liable for any debts of the contractor;
  - If there is a CCN physician incentive plan, include a statement that the CCN shall make no specific payment directly or indirectly under a physician incentive plan to a contractor as an inducement to reduce or limit medically necessary services to a member, and affirmatively state that all incentive plans do not provide incentives, monetary or otherwise, for the withholding of medically necessary care;
  - Require full cooperation in any investigation by DHH, or other state or federal entity or any subsequent legal action that may result from such an investigation;
  - Contain a clause indemnifying, defending and holding DHH and the CCN's members harmless from and against all claims, damages, causes of action, costs for expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the Provider Agreement. This clause must survive the termination of the contract, including breach due to insolvency. DHH may waive this requirement for itself, but not the CCN members, for damages in excess of the statutory cap on damages for public entities, if the contractor is a state agency or subdivision or a public health entity with statutory immunity. All such waivers must be approved in writing by DHH.

- Require that the contractor secure and maintain, during the life of the contract, worker's compensation insurance for all of its employees connected with the work under the Provider Agreement unless such employees are covered by the protection afforded by the CCN. Such insurance shall comply with Louisiana's Worker's Compensation Law;

- Specify that if the contractor delegates or contracts any functions of the CCN, that the contract or delegation includes all the requirements of the Provider Agreement;

- Make provisions for a waiver of those terms of the contract, which as they pertain to Medicaid/CHIP members, are in conflict with the specifications of the Provider Agreement;

- Provide for revoking delegation, or imposing other sanctions, if the contractor's performance is inadequate;

- Provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any new member; and

- Provide details about the following as required by Section 6032 of the federal Deficit Reduction Act of 2005:

  - The False Claim Act;
  - The penalties for submitted false claims and statements;
  - Whistleblower protections; and
  - The law's role in preventing and detecting fraud, waste and abuse, and each person's responsibility relating to detection and prevention.

Ownership and Management Disclosure

The CCN shall fully disclose ownership, management and control of disclosing entities in accordance with the state and federal law.

- Disclosure shall be made on form prescribed by DHH for the areas of ownership and contract interest (42 CFR §455.104, Form CMS 1513); business transactions (42 CFR §455.105); conviction of crimes (42 CFR §455.106); public entities crimes (s. 287.133(3)(a), F.S.); and disbarment and suspension (52 Fed. Reg., pages 20360-20369, and Section 4707 of the Balanced Budget Act of 1997). The forms are available through DHH and are to be submitted to DHH

with the initial application for CCNs and annually to DHH by October 1st of each Provider Agreement year thereafter. In addition, the CCN shall submit to DHH full disclosures of ownership and control of the CCN and any changes in management within five calendar days of knowing the change will occur and at least sixty (60) calendar days before any change in the CCN's ownership or control takes effect.

- The following definitions apply to ownership disclosure:
  - A person with an ownership interest and control interest means a person or corporation that:
    - Owns, indirectly or directly, five percent (5%) or more of the CCN's capital or stock, or receives five percent (5%) or more of its profits;
    - Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the CCN or by it property or assets and that interest is equal to or exceeds five percent (5%) of the total property or assets; or
    - Is an officer or director of the CCN, if organized as a corporation, or is a partner in the CCN, if organized as a partnership.
    - The percentage of director ownership or control is calculated by multiplying the percent of interest that a person owns by the percent of the CCN's assets used to secure the obligation. Thus, if a person owns ten percent (10%) of the stock in a corporation, which owns eighty percent (80%) of the CCN's stock, the person owns eight percent (8%) of the CCN.
  - The following definitions apply to management disclosure:
    - Changes in management are defined as any change in the management control of the CCN. Examples of such changes are those listed below and in Independent Provider subsection, below or equivalent positions by another title.
    - Changes in the board of directors or officers of the CCN, medical director, chief executive officer/administrator, and chief financial officer.

- Changes in the management of the CCN where the CCN has decided to contract out the operation of the CCN to a management corporation. The CCN shall disclose such changes in management control and provide a copy of the contract to DHH for approval at least sixty (60) calendar days prior to the management contract start date.

- By September 1 of each Provider Agreement year, the CCN shall conduct an annual background check with the Louisiana Department of Public Safety and federal background check on all persons with five percent (5%) or more ownership interest in the CCN, or who have executive management responsibility for the CCN, or have the ability to exercise effective control of the CCN.

  - The CCN shall submit the results of the criminal history record check of principals of the CCN to DHH during the CCN Enrollment Process.

  - Principals of the CCN shall be as defined officers, directors, agents and managing employees.

  - The CCN shall submit the results of the criminal history record check of newly hired principals within thirty (30) days of the hire date.

Termination Procedures

The termination notification period required by the CCN for a termination of the Provider Agreement for cause shall be one-hundred and twenty (120) calendar days. The CCN shall work with DHH to create a transition plan, including the orderly and reasonable transfer of member care and progress whether or not the members are hospitalized. The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery, or by facsimile letter followed by certified mail, return receipt requested. The notice of termination shall specify the nature of termination, the extent to which performance of work under the Provider Agreement is terminated, and the date on which such terminating shall become effective. In accordance with Social Security Act 1932(e)(4), DHH will provide the CCN with an opportunity for a hearing through the specified dispute resolution conference process outlined in this ***Guide*** prior to termination with cause.

Withdrawing Services from a Parish or Service Area

If the CCN intends to withdraw services from a parish or service area, the CCN shall provide DHH with one-hundred and twenty (120) calendar days' notice and work with DHH to develop a transition plan. The CCN shall provide written notice of all Medicaid/CHIP

members in that parish at least sixty (60) calendar days before the last day of service. The notice shall contain the same information as required for a notice of termination according to *CCN Requirements Prior to Termination for Cause* in **§13.3.5.8** of the Provider Agreement. The CCN shall also provide written notice of the withdrawal to all providers and contractors in the parish.

Board Resolution/Signature Authority

The CCN, if a corporation, shall secure and attach to the Provider Agreement a formal Board Resolution indicating the signatory to the Provider Agreement is a corporate representative and authorized to sign said Provider Agreement.

Warranty to Comply with State and Federal Regulations

The CCN shall warrant that it shall comply with all state and federal regulations as they exist at the time of the Provider Agreement or as subsequently amended.

Warranty of Removal of Conflict of Interest

The CCN shall warrant that it, its officers, and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services under the Provider Agreement. The CCN shall inquire at least annually of its officers and employees concerning such conflicts, and shall inform DHH promptly of any potential conflict. The CCN shall warrant that it shall remove any conflict of interest prior to signing the Provider Agreement.

If the CCN is a corporation, the following requirement shall be met prior to execution of the Provider Agreement:

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

- If the CCN is a corporation not incorporated under the laws of the state of Louisiana, the CCN shall obtain a Certificate of Authority pursuant to R.S. 12:301-302 from the Louisiana Secretary of State.

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

Emergency Management Plan

In Step 2 of the CCN Enrollment Process and annually by May 31 of each Provider Agreement year, the CCN shall submit to DHH for approval an emergency management plan specifying what actions the CCN shall conduct to **ENSURE** the ongoing provision of

health services in a disaster or man-made emergency, including but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies. If the emergency management plan is unchanged from the previous year, the CCN shall submit a certification to DHH that the prior year's plan is still in place. The plan shall include:

- -Provisions for continuity of operations to provide for continued and sustained operations during an emergency;
- Provisions to ensure continued communications regarding patient needs during an emergency;
- An assessment of its facility to determine if it complies with standards to serve as a Point of Dispensing (POD) Site for staff, staff family members and patients during public health emergencies; and
- Policies and procedures to assist the state in identifying patients (names, addresses, and telephone numbers) with special medical needs and/or transportation needs to build a catalog of individuals that will need assistance during public health emergencies.

Failure to submit and obtain approval of said plan shall be grounds for sanctions.

LEFT BLANK INTENTIONALLY

SECTION 20 - READINESS REVIEW

As part of the CCN enrollment process and after submission of required paperwork referenced in Section 2 of this ***Guide***, DHH will conduct an on-site review of the prospective Coordinated Care Network. The purpose of the on-site review at the CCN's Louisiana location is to assess the capability and capacity of the CCN to meet the requirements set forth in this ***Guide*** and the CCN Model Provider Agreement. DHH will only evaluate required submissions from CCNs that have agreed to participate in an on-site readiness review. Enrollment packets without a completed Readiness Review Agreement (Appendix R) shall be considered incomplete and DHH will take no further action on the application until the Readiness Review Agreement is received.

The following listing of information/documents e required during the CCN enrollment process for DHH approval, shall include, but are not be limited to:

Step 1: Required Submission:

Ownership and Controlling Interest Statement

Medical Necessity Review of Organization (MRNO) certification or authorization from the Louisiana Department of Insurance **or** a copy of the application for certification or authorization that has been submitted to the Louisiana Department of Insurance

Ethical Limitations Statement/Policy

Readiness Review Agreement

HIPAA Business Associate Appendix

Louisiana Secretary of State of Trade Name Certificate

Model Provider Contracts

Description of Proposed Service Area

Attestation of Provider Network Submission

Maximum Medicaid/CHIP Enrollment Capacity

Step 2: Submission of Documents Prior to On-Site Review

Administrative Related:

Current or Pending Administrative Legal Actions or Grievances by Contractor/Member Summary

Current or Pending Administrative Legal Actions or Grievances of Persons Convicted of Criminal Offense Summary

List of Staff Liaisons

Staffing Requirements

Board Resolution/Signature Athority

Assurance from the CCN's legal counsel the CCN is not prohibited by its articles of incorporation, bylaws or the laws under which it is incorporated from performing the services required under the Provider Agreement.

Proof of Coverage

Criminal History Record Check Results

Financial Reports

Medical Record Review Strategy

Contingency Plan for Maintaining Appropriate Staffing

CCN Network Related:

Network Provider Development and Management Plan (NDMP)

Patient-Centered Medical Home Implementation Plan

Provider Complaint System Policy and Procedures

CCN Provider Directory Templates

Internal Claims Dispute Procedures

Quality Deficiencies Reporting Process

CCN Monitoring of Contractors Schedule

Provider Compensation Arrangements

Enrollment Related:

PCP Automatic Assignment Methodology**Marketing Related:**

Marketing Plan and Materials

Network Provider Recruitment Materials

Member Related:

CNN Grievance Policy and Procedures

Changing PCPs within the CCN Policy and Procedures

Transferring between CCNs Policy and Procedures

Member's Welcome Call Script

Initial Member's Education Policy and Procedures

Member's Services Call Line Policy and Procedures

Benefits and Services Related:

Utilization Review Criteria for Service Limits

Referral System Processes

Specialty Healthcare Services Referrals Policy and Procedures

Medical Records

Transferring Medical Record Information to and from FQHCs/RHCs and School-Based Health Clinics Policy and Procedures

Utilization Management Program Policy and Procedures

for Case Management Program Policy and Procedures

Special Health Care Needs Assessment Policy and Procedures

CCMP Policy and Procedures (including a description of Predictive Modeling Methodology)

QAPI Program Description

QAPI Quality Assessment Work Plan

Pharmacy Lock-in Policy and Procedures

Provider Related:

Provider Complaint System Policy and Procedures

Provider Training Manual

Curriculum for Training CCN Providers on the CCN Program

Other:

Termination Transition Plan

Emergency Management Plan

Fraud and Abuse Compliance Plan

Letter of Intent between OPH and CCN to execute an MOU

Sample of hard copy reports

Step 3: MMIS and Enrollment Broker Connectivity

Systems Related:

Receiving Daily Enrollment Updates from the Enrollment Broker Policy and Procedures

Methods to Ensure Remote Access

Security Risk Assessment

Contingency Plan (includes Disaster Recovery Plan and Business Continuity Plan)

Step 4: On-Site Review

Other information as deemed necessary by DHH to ensure readiness of the CCN to enroll members and compliance with the terms and conditions of the Provider Agreement and this Guide.

Step 5: Determination of Adequacy of Network

Network Adequacy Documentation (including Geo-mapping of all network providers by provider type)

Other information as deemed necessary by DHH to ensure readiness of the CCN to enroll members and compliance with the terms and conditions of the Provider Agreement and this *Guide*.

The above list is not all inclusive. It is the CCN's responsibility to submit all documents as required by DHH specified in this ***Guide*** and the Provider Agreement.

LEFT BLANK INTENTIONALLY

SECTION 21 – REPORTING

The following chart contains a summarized list of electronic files or reports to be submitted by CCNs, DHH and the Enrollment Broker. The format and/or layout requirements for each file or report are located in either the *CCN-S Systems Companion Guide*, the *Quality Companion Guide*, the Appendices of this *Guide*, or are IN development. As the following chart may not be all inclusive, it is the CCNs responsibility to ensure that all required files or reports, as stated in the Provider Agreement and the Policy and Procedure Guide, are submitted to DHH in a timely manner.

Unless otherwise specified, deadlines for submitting files and reports are as follows:

- Daily – Within two (2) business days
- Weekly – No later than Wednesday following the reporting week
- Monthly – No later than the fifteenth (15th) day following the end of the reporting month
- Quarterly – No later than the thirtieth (30th) day following the end of the reporting month
- Annual – No later than the ninetieth (90th) day following the end of the reporting year
- Ad hoc reports – Within three (3) business days from the date of the request

Submitter	File or Report Name	Frequency	Format Location	Receiver
CCN	Network Provider and Contractor File	At Readiness Review and Monthly thereafter	Appendix X	DHH – Coordinated Care Section
DHH – Coordinated Care Section	Readiness Review Report	As Appropriate	TBD	CCN
CCN	Patient-Center Medical Home (PCMH) A. PCMH implementation plan B. NCQA PCP-PCMH™ recognition report	During Readiness Review and Annually thereafter	TBD	DHH – Coordinated Care Section

Submitter	File or Report Name	Frequency	Format Location	Receiver
CCN	PCP Care Management Payments	Quarterly	TBD	DHH – Coordinated Care Section
CCN	Model Attestation	Attachment to all reports	Appendix K	DHH – Coordinated Care Section
DHH – FI	New Enrollee File	Daily	Systems Companion Guide TBD	EB
EB	Provider Directory	Weekly	TBD	DHH
EB	Member Linkage File	Daily	Systems Companion Guide TBD	CCN
EB	Member Linkage File	Daily	Systems Companion Guide TBD	DHH – FI
CCN	Member Change Report	Within 5 days of discovery	Systems Companion Guide TBD	DHH – Medicaid Customer Service Unit
CCN and EB	Third Party Liability Form	Daily	Systems Companion Guide TBD	DHH- TPL Section

Submitter	File or Report Name	Frequency	Format Location	Receiver
CCN	Member Services A. Unsuccessful new member contacts B. Member services Call Center	A. Monthly B. Monthly with an Annual Summary	TBD	DHH – Coordinated Care Section
CCN	Specialty Health Care Services Referral Policies	During Readiness Review and annually thereafter and previous to any revisions	TBD	DHH – Coordinated Care Section
EB	Member Disenrollment File	Daily	Systems Companion Guide TBD	DHH – FI
CCN	CCN Disenrollment Report	Monthly	Appendix N	DHH - Coordinated Care Section
DHH – FI	CCN Monthly PMPM Reconciliation	Monthly	Systems Companion Guide TBD	CCN
CCN	Medical Record Review Report	Upon request	TBD	DHH – Coordinated Care Section
CCN	UM reports A. Fraud and Abuse Activity Report B. UM Committee Meeting minutes C. Medical record reviews	A. Quarterly and with an annual summary B. Within 5 business days of each meeting C. Quarterly with an Annual Summary	TBD	DHH – Coordinated Care Section

Submitter	File or Report Name	Frequency	Format Location	Receiver
CCN	CCMP A. Reports B. Predictive Modeling Specifications C. Program Evaluation	A. Quarterly with an Annual Summary B. Readiness review and Annually thereafter C. Annually	TBD	DHH – Coordinated Care Section
CCN	CCN Ownership and Management Disclosure	With initial Provider Enrollment packet and annually, by October 1st, , thereafter	TBD	DHH – Coordinated Care Section
CCN	Emergency Management Plan	During readiness review, 30 days previous to proposed changes, Annual certification	Provider Agreement Section 14.38	DHH – Coordinated Care Section
CCN	Service Authorization Request Report	Upon Request	TBD	DHH – Coordinated Care Section
CCN	Member Satisfaction Survey Report	120 days after Plan year end	Instrument and Survey Results	DHH – Coordinated Care Section
CCN	Provider Satisfaction Survey Report	120 days after Plan year end	Instrument and Survey Results	DHH – Coordinated Care Section
CCN	Evaluation of the Network Provider Development and Management Plan	At the end of the first year of operations and annually thereafter	TBD	DHH – Coordinated Care Section

Submitter	File or Report Name	Frequency	Format Location	Receiver
CCN	Grievance Report	Quarterly, with an annual summary at the end of each calendar year	Appendix L	DHH – Coordinated Care Section
CCN	Marketing Summary Report	Annually	TBD	DHH – Coordinated Care Section
CCN	Pre-processing Report	Daily	Systems Companion Guide TBE	DHH – FI
CCN	Financial Reporting	A. Annual Audited Financial Statement due no later than 6 months after the end of each Provider Agreement year B. Four Quarterly Unaudited Financial Statements no later than 60 days after each calendar quarter C. Monthly if requested by DHH and due within 30 days of each month end	TBD	DHH – Coordinated Care Section
CCN	Quality Assurance (QA) A. QAPI Program description and QAPI Plan B. Impact and effectiveness of QAPI program	A. During readiness review and annually thereafter B. Annually C. Within 3 months of "go live" date and annually thereafter	Quality Companion Guide	DHH – Coordinated Care Section

Submitter	File or Report Name	Frequency	Format Location	Receiver
	evaluation C. Performance Improvement Project descriptions D. Performance Improvement Projects Outcomes E. Quality Measures F. PCP Profile Reports	D. Refer to Quality Companion Guide E. Quarterly with an Annual Summary F. Quarterly with an Annual Summary		
CCN	Case Management Reports	Quarterly and Annually	TBD	DHH – Coordinated Care Section
CCN	Utilization Management Policies and Procedures (including UM review criteria, Case Mgt, CCMP	Annually after Readiness Review and previous to any revisions	TBD	DHH – Coordinated Care Section
CCN	Electronic Data Processing Audit	Annually	TBD	DHH – Coordinated Care Section
DHH - FI	Provider File Record	At onset of implementation and periodically as changes are necessary	Systems Companion Guide TBD	EB and CCNs
DHH – FI	Claims Historical Data and Immunization Data	At onset of implementation and monthly thereafter	Systems Companion Guide TBD	CCN

LEFT BLANK INTENTIONALLY

Appendix A

Definitions

DEFINITIONS

The following terms, as used in this Guide, 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).

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.

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 DHHand based upon the information provided, does not meet theDHH'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 to Medicaid individuals who are eligible for Medicaid due to 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).

Automatic Assignment – The process utilized to enroll into a CCN, using predetermined algorithms, a Medicaid/CHIP eligibles who 1) is not excluded from CCN participation and 2) does not proactively select a CCN within the DHH specified timeframe.

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 (BHSF) —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 overseen 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 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-S Policy and Procedure Guide – The policy and procedure ***Guide*** for Shared Savings Coordinated Care Networks and their providers.

CCN-S Systems Companion Guide – A supplement to the Policy and Procedure Guide that outlines the formatting and reporting requirements concerning claims, interfaces between the FI and the CCN and enrollment broker and the CCN.

Centers for Disease Control/Advisory Committee on Immunization Practices (CDC/ACIP)- The 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 LaCHIP

***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.

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 – A claim that has no defect or impropriety, including any lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment of the claim from being made.

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.

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 Statues, 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.

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.

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.

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.

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.

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**, Fourth edition, 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 - (1) A claim for which has not passed the pre-process edits of the CCN for which Medicaid enrollee is a member; and/or (**2)**A claim for which no payment is made to the network provider by the FI 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 the*Guide*.

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 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.

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.

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 pre-pre-processed or 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 in nature, such as catheters and diapers.

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".

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.

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.

Enrollee – A Medicaid or CHIP eligible who is currently enrolled in a Coordinated Care Network (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 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 eligibles that are excluded from enrollment in a CCN and may not voluntarily enroll.

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 date may be relatively weak or inconclusive. The term applies only to the determination of eligibility for coverage or payment.

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.

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 capital 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.

File - A set of related records compiled in a specified format.

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.

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) 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 32 hours or more per week (exclusive of travel time) for a minimum of four 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 enrollees. 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).

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.

Health Education – materials or activities directed at CCN members to increase awareness and favorably influence the attitudes toward healthy choices on a personal and community level.

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.

ICD-9-CM codes –International Classification of Diseases, 9th Revision, Clinical Modification codes represent a uniform, international classification system of coding disease and injury diagnoses. This coding system arranges diseases and injuries into code categories according to established criteria.

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 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, a CCN can begin the process of establishing all systems for the subsequent enrollment of Medicaid eligibles and service start-up date and preparing for the DHH's Readiness Review. Enrollment of members will not begin until the CCN has passed the Readiness Review or at the "go live" date.

Incentive Arrangement –Any payment mechanism under which a contractor may receive additional funds over and above the rates it was paid for meeting targets specified in the contract.

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.

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.

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; 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 **h**ealth 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 categories of eligible Medicaid/CHIP eligibles who are required to enroll in a Medicaid Coordinated Care Network Program and whose participation is not voluntary.

Marketing means any communication, from an CCN to a Medicaid/CHIP eligible 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 members.

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 the 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; 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 ***Guide*** 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.

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 Necessity Review Organization (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.

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 – As it relates to the Louisiana Medicaid/CHIP Program and the Provider Agreement refers to a Medicaid/CHIP eligible who enrolls in a CCN under the provisions of this agreement .

Member Month – A month of coverage for a Medicaid/CHIPeligible 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 eligibles.

Monetary Penalties– Monetary sanctions that may be assessed when 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 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.

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.

Network – As utilized in the Guide, "network" may be defined as a group of participating providers linked through contractual arrangements to a CCN to provide PCP primary care management.. 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.

Newborn - A live infant born to a CCN member.

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 72 hours, or sooner, 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)*.

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.

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. Also referred to as a Treatment Plan.

Per Capita Prepaid Benchmark (PCPB, the benchmark) – The projected medical costs of the CCN-s member for the evaluation period. The benchmark will be risk-adjusted based upon the health risk associated with the CCN-S membership. The risk-adjusted benchmark is compared to the sum of actual cost and paid enhanced primary care case management fees to determine if shavings have been achieved.

PMPM Rate - The per-member, per-month rate paid to the CCN for the provision of enhanced primary care case management 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.

Potential Enrollee - A Medicaid/CHIP enrollee 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. Guidelines are updated from the Census Bureau's latest published weighted average poverty thresholds.

Pre-Processing – As it relates to the CCN Program, is the processing of all claims by a CCN for services provided to CCN members by Medicaid providers to verify service authorizations and ensure only clean claims are submitted to the FI for payment.

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.

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, t**he 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.

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 DHHassesses the 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 provide primary care case management.

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.

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.

Report - A written document containing pre-defined data elements or record of information.

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. As it relates to the CCN-S Program, the CCN may be at risk for up to fifty (50) percent of the enhanced primary care case manangment fee paid by DHH.

Risk Adjustment - A method for determining adjustments of the PCPB that accounts for variation in health risks among participating CCNs when determining shared savings calculations.

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 map of Louisiana Rural Parishes.

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.

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.

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 provide enhanced primary care case management 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 the ***Guide***, 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).

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 Healthcare 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 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.

Timely – Existing or taking place within the designated period; within the time required by statue 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.

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 t*he 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.

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 **p**rogram 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.

LEFT BLANK INTENTIONALLY

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
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**	**√**	**√**	**√**	**√**
Pediatric and Family Nurse Practitioner	**Mandatory**	**√**	**√**	**√**	**√**
Personal Care Services (EPSDT)	**Mandatory**	N/A	N/A	**√**	**√**
Physician Services	**Mandatory**	**√**	**√**	**√**	**√**
Pregnancy Related Services	**Mandatory**	**√**	**√**	**√**	**√**
Rural Health Clinic	**Mandatory**	**√**	**√**	**√**	**√**
Adult Denture	Optional	N/A	**√**	**√**	**√**
Adult Immunizations	Optional	**√**	**√**	**√**	**√**
Ambulatory Surgical Services	Optional	**√**	**√**	**√**	**√**
Behavioral / Mental Health (Non-EPSDT)	Optional	N/A	**√**	**√**	**√**
Chiropractic Services	Optional	**√**	N/A	N/A	**√**
Clinic Services*	Optional	**√**	**√**	**√**	**√**
Community Mental Health Services	Optional	**√**	**√**	**√**	**√**
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	**√**
Home Health Extended	Optional	**√**	N/A	N/A	**√**
Hospice	Optional	**√**	**√**	**√**	**√**
Inpatient Psychiatric Services for Children under 21 and Adults over 65	Optional	**√**	**√**	**√**	**√**
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	**√**
Personal Care Services (LT-PCS)	Optional	N/A	**√**	N/A	**√**
Pharmacy	Optional	**√**	**√**	**√**	**v**

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**
Podiatry	Optional	√	√	√	√
Prosthetic & Orthotic Devices	Optional	√	√	√	√
Rehabilitative Services **	Optional	√	√	√	√
Targeted Case Management	Optional	√	√	√	√
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 specifed 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 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

08/16/10

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 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 Administrative Performance Measurement Set

Measure	Minimal Performance Standard
Call Abandonment Rate	≤ 5%
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%

Early Warning Systems Measures

Measure	Minimal Performance Standard
Number of PCP locations with verified extended office hours and 24/7 access	50% of PCP office locations must have extended office hours on Saturdays and one weekday each week and 24/7 accessibility.
% of service authorizations processed in timeframes outlined in the contract	100% of service authorizations requested are processed in the timeframes for regular and expedited service authorizations.
Time required to submit CCN-authorized claims to the MMIS	No more than a 2 (two) business day lag time between CCN receipt of claims and MMIS receipt of CCN pre-processed claims for any clean claim pre-processed by the CCN.
Average call wait-time and number and percentage of dropped calls for CCN enrollees	30 seconds or less and call abandonment rate doesn't exceed 5%.
Summaries of any grievances or request for appeals received by the CCN including grievances received via telephone and resolved on the first call to the CCN-S	Number and type of grievances or requests for appeals do not vary more than 10% greater number than other CCN providers.

Appendix D

Performance Improvement Projects

Appendix C: Performance Improvement Projects

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

Appendix E

Attestation of Provider Network

Attestation of Provider Network Submission

(Company Letter Head)

Attestation of Provider Network Submission

For _____ Parish (es)

Date_____

I, _____, as (Title) for (Name of Company), do hereby attest that the information provided on the CCN Provider Network and Contractor Listing Spreadsheet for _____ Parish (es) is (are) accurate, true, and complete.

Based on the required submissions for review and approval of a Shared Coordinated Care Network (CCN), I attest that each contracted provider will be an enrolled Louisiana Medicaid provider as provided in the Provider Agreement between our organization and the Louisiana Department of Health and Hospitals/Bureau of Health Service Financing (DHH), and in the ***CCN-S Policy and Procedure Guide***. I further attest that the necessary information for these providers will be loaded into our organization's system prior to providing services to Louisiana Medicaid/CHIP members. Additionally, I attest that the following requirements will be met:

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

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

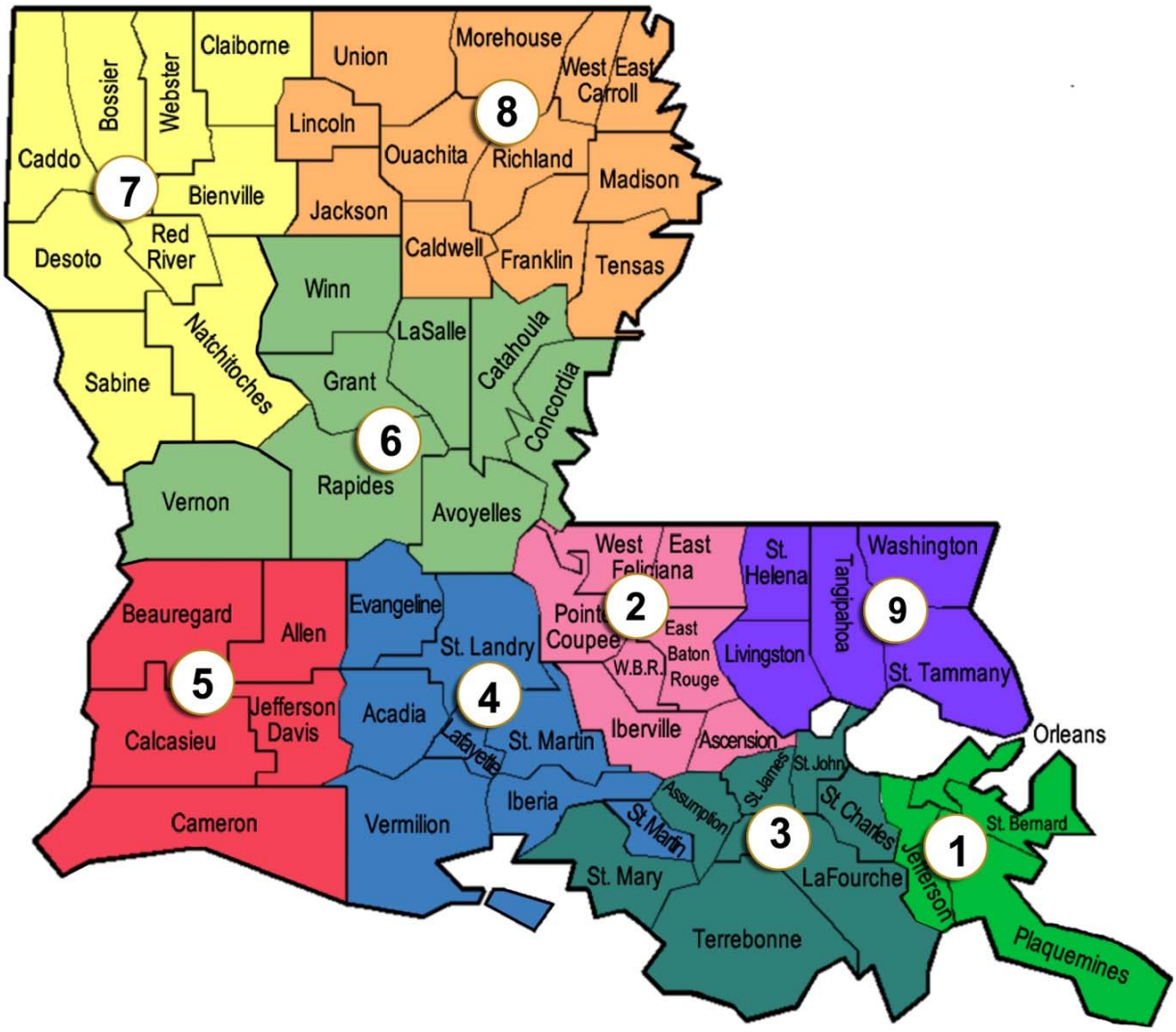
I understand that should DHH determine at a later date that the submitted information is inaccurate, untrue, or incomplete, (Name of company) may be subject to sanctions and/or fines as outlined in SECTION 13 – Sanctions and Dispute Resolution of the Provider Agreement.

_____ _____

Signature/Title Date

Appendix F

DHH Administrative Region Map


Claiborne
Union
Morehouse
West Carroll
East Carroll
Bossier
Webster
Lincoln
8
Caddo
7
Ouachita
Richland
Madison
Bienville
Jackson
Red River
Desoto
Caldwell
Franklin
Tensas
Winn
LaSalle
Catahoula
Natchitoches
Sabine
Grant
Concordia
6
Rapides
Vernon
Avoyelles
West Feliciana
East Feliciana
St. Helena
Washington
Tangipahoa
Beauregard
Allen
Evangeline
Point Coupee
2
East Baton Rouge
Livingston
9
St. Landry
W.B.R.
St. Tammany
5
Jefferson Davis
Acadia
4
Calcasieu
Lafayette
St. Martin
Iberville
Ascension
Orleans
St. James
St. John
Iberia
Assumption
St. Charles
Cameron
Vermilion
St. Martin
3
St. Bernard
1
St. Mary
LaFourche
Jefferson
Terrebonne
Plaquemines

Appendix G

Member's and Potential Member's Bill of Rights

Member's and Potential Member's Bill of Rights

Each Member is guaranteed the following rights:

- To be treated with respect and with due consideration for his/her dignity and privacy.
- To participate in decisions regarding his/her health care, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To be able to request and receive a copy of his/her medical records, (one copy free of charge) and request that they be amended or corrected.
- To receive health care services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- To receive all information— e.g., enrollment notices, informational materials, instructional materials, available treatment options and alternatives.—in a manner and format that may be easily understood as defined in the Provider Agreement and this ***Guide***.
- To receive assistance from both DHH and the Enrollment Broker in understanding the requirements and benefits of the CCN.
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To be notified that oral interpretation is available and how to access those services.

- As a potential member, to receive information about the basic features of the CCN program; which populations may or may not enroll in the program and the CCN's responsibilities for coordination of care in a timely manner in order to make an informed choice.

- To receive information on the CCN's services, to include, but not limited to:
    - Benefits covered.
    - Procedures for obtaining benefits, including any authorization requirements.
    - Any cost sharing requirements.
    - Service area.
    - Names, locations, telephone numbers of and non-English language spoken by current contracted providers, including at a minimum, primary care physicians, specialists, and hospitals.
    - Any restrictions on member's freedom of choice among network providers.
    - Providers not accepting new patients.
    - Benefits not offered by the Contractor but available to members and how to obtain those benefits, including how transportation is provided.

- To receive a complete description of disenrollment rights at least annually.

- To receive notice of any significant changes in the Benefits Package at least 30 days before the intended effective date of the change.

- To receive information on the Grievance, Appeal and State Fair Hearing procedures.

- To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
    - What constitutes an emergency medical condition, emergency services, and post-stabilization services.
    - That Emergency Services do not require prior authorization.
    - The process and procedures for obtaining Emergency services.
    - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract.
    - Member's right to use any hospital or other setting for emergency care.
    - Post-stabilization care services rules as detailed in 42 CFR §422.113(c).

- To receive the CCN's policy on referrals for specialty care and other benefits not provided by the member's PCP.

- To have his/her privacy protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

- To exercise these rights without adversely affecting the way the CCN, its providers or DHH treat the members.

APPENDIX H

Certification Letter of Actuarial Soundness of PMPM Rates

Louisiana Department of Health and Hospitals
Shared Provider Agreement Rate Setting

Actuarial Certification

April 2010 – June 2012 Medicaid Coordinated Care Network PMPM Rate

TO BE PROVIDED BY MERCER

Appendix I

Guidelines for Involuntary Member Disenrollment

Generally the effective dates of Disenrollment are prospective. Effective dates for other than routine Disenrollments are described below.

Guidelines for Involuntary Member Disenrollment *	
Reason for Involuntary Disenrollment	**Disenrollment Effective Date**
Loss of Medicaid and CHIP eligibility	Member will be auto-disenrolled during next processing cycles.
Death of member	Member will be disenrolled at the end of the month of death. PMPM for months following the month of death will be recouped.
Intentional submission of fraudulent information	Member will be disenrolled at the earliest effective date allowed.
Member moved outside of service area	First day of the month after the update of the system with the new address.
Member moves out of state	Member will be disenrolled at the end of the month of the move. Any premiums for months following the month of the move will be recouped.
Member elects hospice	Member will be disenrolled on the first day of the month following hospice election.
Member becomes Medicare eligible	Member will be auto-disenrolled during next processing cycles retroactive to effective date of Medicare enrollment. Any PMPM paid during overlap over coverage will be recouped.
Member in LTC/NH	Member will be disenrolled on the first day of the month following waiver election or admission into NH.
Member elects Waiver Services	Member will be disenrolled on the first day of the month following entry into waiver service.
Loss of CCN's participation	Member will be disenrolled based on CCN's termination date.
Member with more than one Medicaid Identification Number is enrolled in a CCN under more than one of the Medicaid Identification Numbers	First day of the month the duplicate enrollment began.
Incarceration	First day of the month following incarceration (note-CCN is at risk for core benefits and services only to the date of incarceration and is entitled to the PMPM for the month of incarceration)
Member enrolled in Medicare	First day of month following identification of Medicare coverage. PMPM paid up to the effective date of Medicare coverage will be recouped.

Guidelines for Involuntary Member Disenrollment *	
Reason for Involuntary Disenrollment	**Reason for Involuntary Disenrollment**
Member fails to follow rules of CCN.	Member will be disenrolled at the earliest effective date allowed by system edits.
Recipient on Inconsistent Parish Report	Member will be disenrolled at the earliest effective date allowed by system edits following verification of new address.
Member status changes to family planning only	If the status of the member changes while in the hospital to a category where the hospital and physician charges would not be paid under FFS, the patient would be responsible for both the facility and physician charges for the uncovered portion of the stay (from the date that their status changes to FP services only).
Member terminates with one CCN and joins another while in hospital (disenrollment/enrollment date occurs while in hospital)	The CCN that covers a member on the day of admission to a hospital will be responsible for the entire stay (facility charge), even if their insurance carrier changes while they are inpatient. The date of service will dictate the responsible party for physician charges.

**DHH policy allows special exceptions to the disenrollment provisions listed above when in the best interest of the member and/or the Medicaid program. These exceptions will be considered on a case by case basis.*

***Inmate is defined as a person incarcerated in or otherwise confined to a correctional institution (i.e., jail). This does not include individuals on Probation or Parole or who are participating in a community program.*

Appendix J

Provider's Bill Of Rights

PROVIDER'S BILL OF RIGHTS

Each CCN network provider who contracts with a CCN to furnish services to the members shall be assured of the following rights:

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

APPENDIX K

CCN Model Attestation Letter

Model Attestation Letter

(Company Letter Head)

Attestation for Reports

Date_____

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

I understand that should DHH determine the submitted information is inaccurate, untrue, or incomplete, (Name of company) may be subject to monetary penalties or sanctions and/or fines as outlined in SECTION 13 of the Provider Agreement and SECTION 18 of the CCN Shared Policy and Procedure Guide.

_____ _____

Signature/Title Date

APPENDIX L

Grievance Reporting Requirements

20__ Coordinated Care Network
Grievance and State Fair Hearing Report

I. Contact Information

Date: _____

Coordinated Care Network Name: _____

Contact Name: _____

Contact Title: _____

Address: _____

_____

_____

Telephone Numbers:

Local: _____

Toll Free: _____

E-mail Address: _____

Name of IRO(s): _____

(If CCN has more than 3 IROs, please attach a separate sheet.) _____

_____

20__ Coordinated Care Network
Grievance and State Fair Hearing Report

II. Review Activities

	Grievances	State Fair Hearings
Number of grievances reviewed:		
Number of grievances/State Fair Hearings resolved:		
* Percentage of overturned decisions:		
Number still pending at end of 20__:		
Number of grievances considered ineligible:		
Average length of time to complete each grievance/State Fair Hearing process:		
Number of cases where CCN reversed its decision in the member's favor:		

* In cases where the decision was overturned in the member's favor, what was the most common reason? (e.g. availability of new information):

List the top 5 services that were most commonly the subject of grievances/State Fair Hearings (e.g., emergency room care, durable medical equipment).

1.
2.
3.
4.
5.

List the top 5 issues resulting in referral to an independent review organizations.

1.
2.
3.
4.
5.

20__ Coordinated Care Network
Grievances Summary Report
***Grievances received or completed in 20__ (If grievance was not completed in 20__, write "pending" in column 3.)**

Grievance Reporting Period _____

(1) Member ID	(2)* Date Grievance Was Received	(3)* Date Grievance Was Completed	(4) Days to Resolve	(5) Determination Upheld, Overturned, Partial	(6) Type of Service Denied (Be Specific)	(7) Reason For Grievance (Use Number Code from Grievance Reason Summary)	(8) Explain Reason Grievance Was Upheld or Overturned	(9) Individual/Entity Requesting Review

20__ Coordinated Care Network
State Fair Hearing
Annual Summary Report

***State Fair Hearings request received or completed in 20__ (If hearing was not completed in 20__, write "pending" in column 3.)**

State Fair Hearings Reporting Period _____

(1) Member ID	(2)* Date Request Was Received	(3)* Date Hearing Was Completed	(4) Days to Resolve	(5) Determination Upheld, Overturned, Partial	(6) Type of Service Denied (Be Specific)	(7) Reason For State Fair Hearing (Use Number Code from SFH Reason Summary)	(8) Explain Reason Initial Decision Was Upheld or Overturned	(9) Individual/Entity Requesting Review

Grievance and State Fair Hearing Reason Summary Chart

Denial Reason Number Code	Denial Reason	Number of Grievances	Number of State Fair Hearing Requests
1	Benefit Limitation/Exclusion		
2	Clinical Criteria Not Met - Assistant Surgeon		
3	Clinical Criteria Not Met - Durable Medical Equipment		
4	Clinical Criteria Not Met - Inpatient Admissions		
5	Clinical Criteria Not Met - Medical Procedure		
6	Authorization		
7	Lack of Information from Provider		
8	Level of Care Dispute		
9	Not a State Plan Benefit		
10	Other		
TOTALS			

DO NOT ADD OR CHANGE REASON CODES

Appendix M

Rules Regarding Physician Incentive Plan

Rules Regarding Physician Incentive Plans

The CCN Physician Incentive Plan (herein referred to as Plan) must be approved by the State and any payments under the Plan must result in the provision of medically necessary care provided in accordance with the terms of the CCN Provider Agreement and ensure:

(1) Services are offered in an amount, duration and scope that is no less than that furnished to beneficiaries under fee-for-service Medicaid;

(2) Services are offered in sufficient amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished;

(3) Providers under a Plan do not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition;

(4) Authorization of services is consistent with the CCN requirements for medical necessity; and

(5) Plan is structured so as *not* to provide incentives for the provider to deny, limit or discontinue medically necessary services to any enrollee.

Appendix N

CCN Disenrollment Report

CCN Disenrollment Report

TO BE DETERMINED

APPENDIX O

Marketing Guidelines

Marketing Guidelines

The following guidelines provide a framework for CCNs in the development of marketing plans, materials and activities.

If a CCN's marketing activities do not comply with the marketing guidelines noted in Section 7 – Marketing of the Provider Agreement and Section 12 – Marketing and Outreach in the ***Guide***, DHH may take corrective action to protect the interests of prospective/potential/current enrollees and the integrity of the CCN-S program.

Written Material Guidelines

The CCN must comply with the following requirements as it relates to all written member materials, regardless of the means of distribution (verbal, printed, web, advertising, direct mail, etc.):

- All member materials must be 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 grade 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 reading-level standard.

- If a person making a testimonial or endorsement for a CCN has a financial interest in the company, such fact must be disclosed in the marketing materials.

- All printed member materials must be in accordance with standards for printing by state agencies established pursuant to R.S. 43:31.

- All written materials must be clearly legible with a minimum font size of 12 point, with the exception of member ID cards, and unless otherwise approved by DHH;

- The quality of materials used for printed materials shall be, at a minimum, equal to the materials used for printed materials for the CCN's commercial plans if applicable;

- No materials can use the seal of the state of Louisiana, the logo of DHH, the branded name or logo of any program provided by DHH, or any logos or wording used by government agencies without written permission from DHH;

- The CCNs name, mailing address (and physical location, if different) and toll-free number must be prominently displayed on the cover of all multi-paged marketing materials;

- All written marketing and informational materials must be available in English, Spanish and Vietnamese upon request. Within ninety (90) calendar days of notice from DHH, all written marketing and informational materials must be translated and made available to each Limited English Proficiency group identified by DHH. Limited English Proficiency needs will include any language that is spoken by at least 5% of the CCN's potential enrollees in the CCN's parish or service area or 1,000 potential enrollees, whichever is less.

- All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services;

- All written materials related to CCN and PCP enrollment shall advise potential enrollees to verify with the medical services providers they prefer or have an existing relationship with, that such medical services providers are participating providers of the selected CCN and are available to serve the enrollee.

- Alternative forms of communication must be provided for persons with visual, hearing, speech, physical or developmental disabilities. These alternatives must be provided at no expense to the member.

- The CCN must provide written notice to members of any changes in policies or procedures described in written materials previously sent to members. The CCN must provide written notice at least thirty (30) days before the effective date of the changes.

- Marketing materials must be made available through the CCN's entire service area. Materials may be customized for specific parishes and populations within the CCNs service area.

- All marketing activities should provide for equitable distribution of materials without bias toward or against any group.

- Any information that is directly related to members or potential members must be approved by DHH as described in the ***Guide***.

- Marketing materials shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Materials must not make any statement (written or verbal) that contains false, confusing, misleading or ambiguous information. This includes statements which mislead or falsely describe covered or available services, membership or availability of providers and qualifications and skills of providers and assertions the recipient of the communication must enroll in a specific plan in order to obtain or not lose benefits or a specific CCN's plan is

endorsed by the federal or state government, or similar entity. Materials must not make broad, sweeping statements.

- Marketing materials must accurately reflect general information, which is applicable to the average consumer of the CCN.
- Materials may not make reference to incentives that may be available to individuals after they enroll in the CCN.
- Marketing materials shall not mention other CCNs or their products by name.

APPENDIX P

CCN Initiated Disenrollment Request

CCN Initiated Disenrollment Request

The member(s) listed below is to be disenrolled from the following CCN _____ _____ for the reason listed below. Please check all that apply.

- ☐ Member demonstrates a pattern of disruptive abusive behavior that could be construed as non-compliant and is not caused by a presenting illness; (Attach narrative with additional information)
- ☐ Member's utilization of services is fraudulent or abusive; (Attach narrative with additional information)
- ☐ Member is placed in a long-term care nursing facility or 1915c Waiver;
- ☐ Member is placed in an intermediate care facility for the developmentally disabled (ICF/DD);

Address	Phone Number
c/o _____ _____ Street _____ _____ City/State/Zip _____	(_____) _____ _____ County _____

- ☐ Member moved out of the service area and plan does not operate in the new service area;
- ☐ Member has died or is incarcerated. Date of death or incarceration _____
- ☐ Other _____

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

Signature: _____ Date: _____

The Louisiana Department of Health and Hospitals will determine if the CCN has shown a good cause to disenroll the Medicaid/CHIP member. The CCN Liaison will give written notification to the CCN of the decision. Medicaid/CHIP members have the right to appeal enrollment and disenrollment decisions to the Louisiana Department of Health and Hospitals.

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

Mail completed form to: Louisiana Medicaid Coordinated Care Section
Attn: Louisiana Medicaid Enrollment Broker
10101 Siegen Lane
Baton Rouge, Louisiana 70810

APPENDIX Q

Coordination of CCN Fraud and Abuse Complaints and Referrals

COORDINATION OF CCN FRAUD AND ABUSE COMPLAINTS AND REFERRALS

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

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

- The fraud hotline toll free number, 1-800-488-2917;
- U.S. mail, P.O. Box 91030, Baton Rouge, LA 70821;
- Fraud reporting fax line 225-219-4155; and/or
- DHH's website www.dhh.louisiana.gov and click on the "Report Medicaid Fraud" button.

Coordination Involving Fraud and Abuse Complaints Received by DHH:

- If DHH receives a complaint about a CCN member's **eligibility** for Medicaid/CHIP, the complaint is referred within three business days to the Medicaid Eligibility Field Operations Section.

- If DHH receives a complaint about a CCN member's **utilization of benefits**, the complaint is referred within three business days to the appropriate CCN.

- If DHH receives a complaint about a provider contracted with CCN(s), the complaint is referred to Program Integrity and Medicaid Coordinated Care Section for preliminary screening for fraud and abuse and/or referral to the appropriate CCN(s) for action.

Coordination for Fraud and Abuse Complaints Received by CCN:

- If the CCN receives a complaint about a member's eligibility for Medicaid/CHIP, the complaint is referred to Medicaid Eligibility Field Operations Section. The referral is made within three business days.

- If the CCN receives a complaint about a member's utilization of benefits, the complaint is handled internally in accordance with the CCN's fraud and abuse/program integrity plan.

- If the CCN receives a complaint against a health care provider or contractor in its network, the CCN will investigate in accordance with its fraud and abuse/ program integrity plan.

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

Fraud and Abuse Referrals:

- If a complaint or the findings of a preliminary investigation give the CCN reason to believe that fraud or abuse of the Medicaid program has occurred, the CCN must report this information to the Program Integrity Section within three (3) business days. Any suspicion or knowledge of fraud and abuse would include, but not be limited to, the false or fraudulent filings of claims and the acceptance or failure to return monies allowed or paid on claims known to be fraudulent, on the part of members, employees, providers, or contractors. The CCN should submit all relevant information about the case, including its findings and the details of its investigation through one of the four mechanisms DHH receives complaints

- Upon suspicion of Medicaid fraud on the part of a member enrolled in a CCN, the CCN will refer the complaint to the Program Integrity Section within three (3) business days with all supporting evidence so the complaint can be referred to the Medicaid Eligibility Field Operations and Medicaid Fraud Control Unit in the Louisiana Attorney General's Office.

- The Coordinated Care Section will send a copy to Program Integrity of any fraud and abuse reports received from the CCNs within three (3) business days.

- For fraud cases against providers and members either initiated or referred by other Offices/Bureaus within DHH, Office/Bureau will inform the CCN and the Medicaid Coordinated Care Section when the case results in a criminal conviction, sanction, loss of benefits, and/or exclusion from the Medicaid program.

Excluded Providers:

- The Program Integrity Section will update the Health Care Integrity and Protection Databank (HIPDB) to reflect all permissive and mandatory provider exclusions. The

CCN shall be required to query the HIPDB for excluded providers. DHH will allow the CCN to become an authorized agent in order for the CCN to gain access to the HIPDB. Information concerning the data bank can be located at: http://www.npdb-hipdb.hrsa.gov/index.html

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

Information Sharing:

The CCN will meet DHH Program Integrity Unit and Attorney General Fraud Control Unit (MFCU) on a quarterly basis to exchange information and collaboration on suspected fraud and abuse occurrences.

Appendix R

Readiness Review Agreement

Louisiana Medicaid

Coordinated Care Network

Agreement to Participate in On-Site Readiness Reviews

_____ hereby agrees to participate in the Readiness Review process. It is understood by the undersigned authority that failure to participate in the Readiness Review shall result in discontinuation of the Provider Agreement Enrollment Process.

The undersigned further understands that if the CCN does not pass the Readiness Review, the Provider Agreement enrollment process will be discontinued.

Subsequent request for enroll shall be processed as a new application.

_____

Name and Title of Authorized Signature

_____

Signature

_____

Date

Appendix S

Person First Policy

POLICY NUMBER:	0004-03
SUBJECT:	Communications With Respect To Persons Served By DHH
CONTENT:	Use of respectful language when referring to individuals with disabilities who are served by the Department
EFFECTIVE DATE:	Issued: December 31, 2003
INQUIRIES:	Sheila Moore Office of the Secretary 1201 Capitol Access Road, P. O. Box 629 Baton Rouge, Louisiana 70821-0629 Phone (225) 342-8881 FAX (225) 342-5568

COMMUNICATIONS WITH RESPECT TO PERSONS SERVED BY DHH

I. Purpose

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

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

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

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

II. Applicability

This policy applies to all DHH employees.

III. Implementation

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

IV. Policy

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

A. The Department recognizes that disability is a natural part of the human experience. It is, like gender and ethnicity, one of many characteristics of being human.

B. The Department acknowledges that words have power, the power to shape the way people think, feel, and act towards others. When a group of people wants understanding and acceptance, attention to the language used in talking and writing about them is particularly important.

C. Departmental employees have the opportunity to impact how people with disabilities are viewed, treated and responded to. The Department, therefore, adopts the use of positive language.

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

V. Guidelines for Using Positive Language

A. In preparing documents and presentations and in general oral conversations, each employee of the Department should consider the following:

1. The people we serve are first and foremost multi-dimensional human beings like everyone else but whom, secondarily, have a disorder with which they are dealing. A person does not equate to a disability, i.e., a person may have a condition like mental retardation, but would not be referred to as a mental retardate. Likewise, it is preferable to say that a person has a disability, rather than he is disabled. Phrases such as "developmentally disabled children:" should be replaced by "children with developmental disabilities."

2. Ask yourself whether it is necessary to mention disability in all cases. The term should be used only when it is significant to the conversation or understanding of written material.

3. Emphasis should to be placed on abilities, rather than limitations. Consider, for example, that wheelchairs allow people to be mobile, rather than being confined.

4. Avoid negative words or those that sensationalize disabilities. Words like "suffer", "tragedy", "problem" and "afflicted" are considered offensive.

5. "Problems" or "deficits" should be framed as needs. This is the traditional way that we refer to the supports we all need to operate, i.e., "I need glasses," rather than "I have a visual deficit."

6. Avoid euphemisms such as "differently-abled," and "special," when what is meant is segregated. The exception is where the term "special" is used as a part of a proper name as in "Special Olympics."

B. It is not the intent of this policy to impede communications in medical settings. Where the general population would be referred to as "clients," that same term is properly used in reference to persons with disabilities.

VI. Responsibility

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

b. Each office/division/bureau is responsible for providing orientation, training, information and educational materials regarding the use of positive language to its employees.

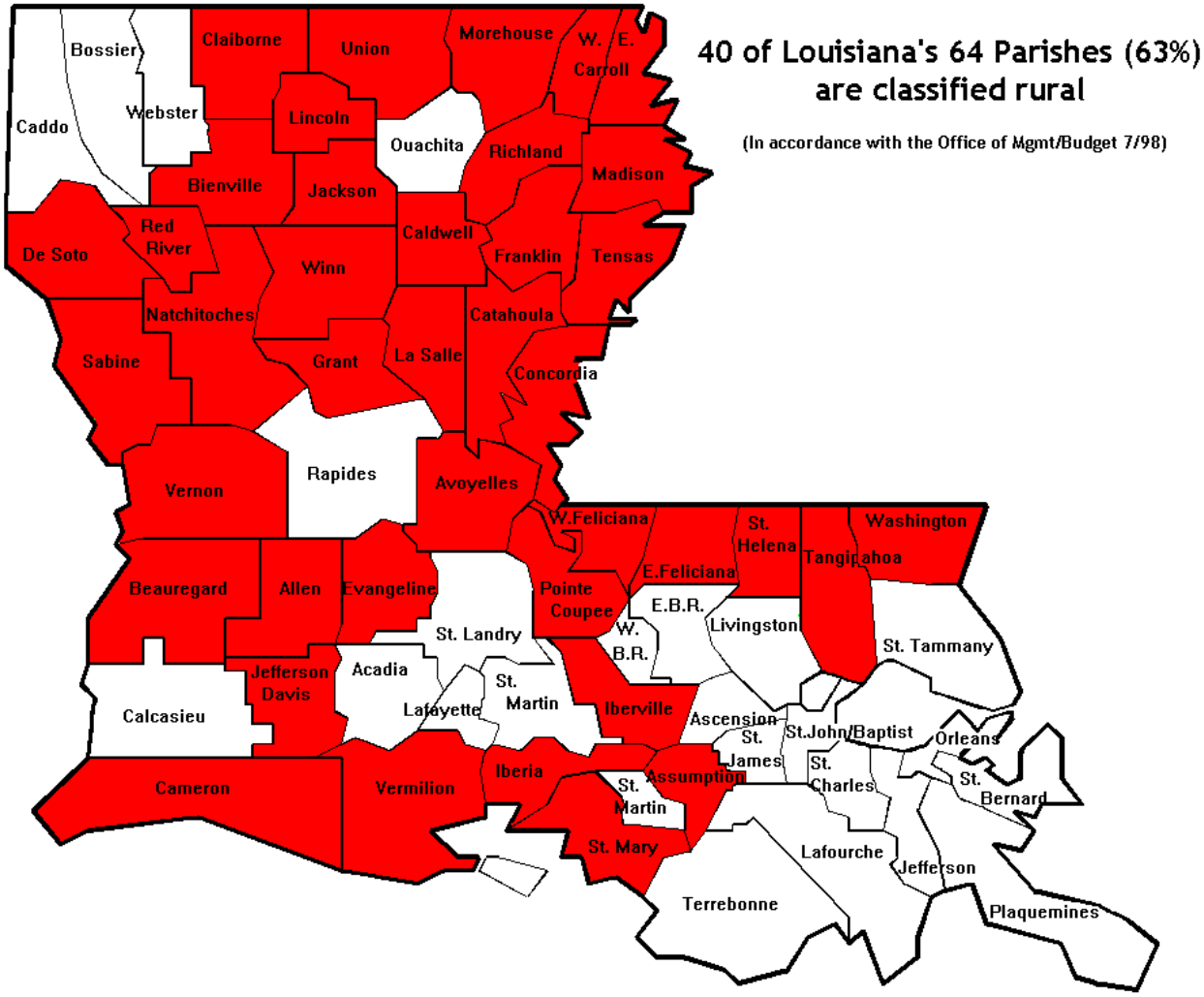
c. Within each office/division/bureau, written materials, particularly those that will be shared with the public, are to be reviewed prior to distribution to ensure the use of respectful language. It is also important that positive language be used in individual planning documents and other materials written about specific individuals being served.

Notations:

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

Appendix T

Louisiana Map of Rural Parishes


40 of Louisiana's 64 Parishes (63%)
are classified rural
(In accordance with the Office of Mgmt/Budget 7/98)
Bossier
Claiborne
Union
Morehouse
W.
E.
Carroll
Caddo
Webster
Lincoln
Ouachita
Richland
Madison
Bienville
Jackson
Red
River
Caldwell
De Soto
Winn
Franklin
Tensas
Natchitoches
Catahoula
Sabine
Grant
La Salle
Concordia
Vernon
Rapides
Avoyelles
W.Feliciana
St.
Helena
Washington
Tangipahoa
E.Feliciana
Beauregard
Allen
Evangeline
Pointe
Coupee
E.B.R.
Livingston
St. Landry
W.
B.R.
St. Tammany
Jefferson
Davis
Acadia
St.
Martin
Calcasieu
Lafayette
Iberville
Ascension
St.
James
St.John/Baptist
Orleans
St.
Charles
St.
Bernard
Cameron
Vermilion
Iberia
Assumption
St.
Martin
St. Mary
Lafourche
Jefferson
Terrebonne
Plaquemines

Appendix U

Monthly Marketing Plan Report

TO BE DETERMINED

Appendix V

TPL Identification Form for Traditional Medicare

Department of Health and Hospitals
Medicaid Recipient Insurance Information Update
(Traditional MEDICARE Only)

Fax #: 225-342-1376 Phone #: 225-342-8662

Date of Submission:_____ Provider Medicaid ID:_____

Provider Name:_____ Phone #:(____)_____-_____

Submitter Name:_____ Fax #:(____)_____-_____

Submission Status (check one): ☐ General TPL update

☐ Awaiting claim processing with updated TPL

☐ Pharmacy awaiting TPL update to fulfill prescription

Recipient Information:

Patient Name: _____ Parish of Residence:_____

Medicaid ID #:_____ Date of Birth (mm/dd/yyyy): ___/___/_____

Hospital Account #:_____ Date of Service (mm/dd/yyyy): ___/___/_____

Please update the patient's medical file by **ADDING** the following insurance:

Insurance Name:_____ Address:_____

_____

Policy Holder Information:	**Policy Information:**
Policy Holder SSN:____-____-_____	Policy #:_____
Policy Holder Name:_____	Group #:_____
Policy Holder DOB (mm/dd/yyyy): ___/___/_____	Coverage Eff. Date (mm/dd/yyyy): ___/___/_____
	Coverage End Date (mm/dd/yyyy): ___/___/_____
	Carrier Code:_____

Please update the patient's medical file by **REMOVING** the following insurance:

Insurance Name:_____ Address:_____

_____

Policy Holder Information:	**Policy Information:**
Policy Holder SSN:____-____-_____	Policy #:_____
Policy Holder Name:_____	Group #:_____
Policy Holder DOB (mm/dd/yyyy): ___/___/_____	Coverage Eff. Date (mm/dd/yyyy): ___/___/_____
	Coverage End Date (mm/dd/yyyy): ___/___/_____
	Carrier Code:_____

PRIVACY AND CONFIDENTIALITY WARNING

This Fax may contain Protected Health Information, Individually Identifiable Health Information and other information which is protected by law. The information is intended only for the use of the intended recipient. If you are not the intended recipient, you are hereby notified that any review, disclosure/re-disclosure, copying, storing, distributing or the taking of action in reliance on the content of this Fax and any attachments thereto, is strictly prohibited. If you have received this Fax in error, please notify the sender immediately and destroy the contents of this Fax and its attachments by deleting any and all electronic copies and any and all hard copies regardless of where they are maintained or stored.

Revised 7/1/09

Instructions on how to fill out the Medicaid Recipient Insurance Information Update for Traditional Medicare Coverage

1) Provider information
    a. Date of submission (insert in (mm/dd/yyyy))
    b. Provider name (insert the provider name)
    c. Submitter name (person filling out the form)
    d. Submission status check one – with regard to a CCN this should always be (General TPL Update)
    e. Provider Medicaid ID (insert the Provider billing ID)
    f. Phone number (insert the phone number of the person filling out the form)
    g. Fax number (insert the fax number of the person filling out the form)
2) Recipient Information
    a. Patient name (insert enrollee name – First and Last Name)
    b. Medicaid ID number (13 digit ID number of enrollee)
    c. Hospital account number (Your patient account number if different from above)
    d. Parish of residence (insert the parish of where the enrollee resides)
    e. Date of birth (mm/dd/yyyy) (date of birth of the enrollee in the format indicated)
    f. Date of service (mm/dd/yyyy) (date services were rendered to the enrollee in the format indicated)
3) Adding Insurance to the file
    a. Insurance name (insert the insurance name)
    b. Address (insert the insurance's billing address)
4) Policy Holder Information
    a. Policy holder SSN (insert the policy SSN as specified)
    b. Policy holder name (insert the first and last name of the policy holder)
    c. Policy holder DOB (mm/dd/yyyy) (insert the date of birth of the policy holder in the format indicated)
5) Policy Information
    a. Policy number (insert the policy number)
    b. Group number (insert the group number)
    c. Coverage Effective data (mm/dd/yyyy) (insert the effective date of the insurance in the format indicated)
    d. Coverage end date (mm/dd/yyyy) (insert the coverage end date of the insurance if the policy has already ended, in the format indicated, otherwise leave blank)
    e. Carrier Code (Not applicable)
6) Removing the following insurance (this is not applicable, if an enrollee had insurance they would not have been enrolled into the CCN.

Fax the form for adding Medicare coverage to 225-342-1376, need to speak to someone about the form call 225-342-8662.

Appendix W

TPL Identification Form for Traditional Medicaid

Department of Health and Hospitals
Medicaid Recipient Insurance Information Update

Fax #: 1.877.204.1325 Phone #: 1.877.204.1324

Date of Submission:_____ Provider Medicaid ID:_____

Provider Name:_____ Phone #:(___)_____-_____

Submitter Name:_____ Fax #:(___)_____-_____

Submission Status (check one): ☐ General TPL update

☐ Awaiting claim processing with updated TPL

☐ Pharmacy awaiting TPL update to fulfill prescription

Recipient Information:

Patient Name: _____ Parish of Residence:_____

Medicaid ID #:_____ Date of Birth (mm/dd/yyyy): ___/___/_____

Hospital Account #:_____ Date of Service (mm/dd/yyyy): ___/___/_____

Please update the patient's medical file by **ADDING** the following insurance:

Insurance Name:_____ Address:_____

_____

Policy Holder Information:	**Policy Information:**
Policy Holder SSN:____-____-_____	Policy #:_____
Policy Holder Name:_____	Group #:_____
Policy Holder DOB (mm/dd/yyyy): ___/___/_____	Coverage Eff. Date (mm/dd/yyyy): ___/___/_____
	Coverage End Date (mm/dd/yyyy): ___/___/_____
	Carrier Code:_____

Please update the patient's medical file by **REMOVING** the following insurance:

Insurance Name:_____ Address:_____

_____

Policy Holder Information:	**Policy Information:**
Policy Holder SSN:____-____-_____	Policy #:_____
Policy Holder Name:_____	Group #:_____
Policy Holder DOB (mm/dd/yyyy): ___/___/_____	Coverage Eff. Date (mm/dd/yyyy): ___/___/_____
	Coverage End Date (mm/dd/yyyy): ___/___/_____
	Carrier Code:_____

PRIVACY AND CONFIDENTIALITY WARNING

This Fax may contain Protected Health Information, Individually Identifiable Health Information and other information which is protected by law. The information is intended only for the use of the intended recipient. If you are not the intended recipient, you are hereby notified that any review, disclosure/re-disclosure, copying, storing, distributing or the taking of action in reliance on the content of this Fax and any attachments thereto, is strictly prohibited. If you have received this Fax in error, please notify the sender immediately and destroy the contents of this Fax and its attachments by deleting any and all electronic copies and any and all hard copies regardless of where they are maintained or stored.

Revised 7/1/09

Instructions on how to fill out the Medicaid Recipient Insurance Information Update

1) Provider information
    a. Date of submission (insert month, day, year) example 01,01,2011
    b. Provider name (insert the provider name)
    c. Submitter name (person filling out the form)
    d. Submission status check one – with regard to a CCN this should always be (General TPL Update)
    e. Provider Medicaid ID (insert the Provider billing ID)
    f. Phone number (insert the phone number of the person filling out the form)
    g. Fax number (insert the fax number of the person filling out the form)
2) Recipient Information
    a. Patient name (insert enrollee name – (First and Last Name)
    b. Medicaid ID number (13 digit ID number of enrollee)
    c. Hospital account number (Your patient account number if different from above)
    d. Parish of residence (insert the parish of where the enrollee resides)
    e. Date of birth (mm/dd/yyyy) (date of birth of the enrollee in the format indicated)
    f. Date of service (mm/dd/yyyy) (date services were rendered to the enrollee in the format indicated)
3) Adding Insurance to the file
    a. Insurance name (insert the insurance name)
    b. Address (insert the insurance's billing address)
4) Policy Holder Information
    a. Policy holder SSN (insert the policy SSN as specified)
    b. Policy holder name (insert the first and last name of the policy holder)
    c. Policy holder DOB (mm/dd/yyyy) (insert the date of birth of the policy holder in the format indicated)
5) Policy Information
    a. Policy number (insert the policy number)
    b. Group number (insert the group number)
    c. Coverage Effective data (mm/dd/yyyy) (insert the effective date of the insurance in the format indicated)
    d. Coverage end date (mm/dd/yyyy) (insert the coverage end date of the insurance if the policy has already ended, in the format indicated, otherwise leave blank)
    e. Carrier Code (insert the carrier code from the LAMedicaid site – this is a specific code for Louisiana Medicaid)
6) Removing the following insurance (this is not applicable, if an enrollee had insurance they would not have been enrolled into the CCN.

Fax the form for adding insurance or a Medicare advantage plan to 1-877-204-1325, need to speak to someone about the form call 1-877-204-1324.

APPENDIX X

FISCAL INTERMEDIARY PAYMENT SCHEDULE

Louisiana Department of Health and Hospitals DRAFT

Medicaid CCN Payment Schedule

Updated: 7/22/2010

Year	Month	EFT Date	Expected Date of Deposit
2011	April	04/04/2011	04/05/2011
	May	05/03/2011	05/04/2011
	June	06/07/2011	06/08/2011
	July	07/05/2011	07/06/2011
	August	08/02/2011	08/03/2011
	September	09/06/2011	09/07/2011
	October	10/04/2011	10/05/2011
	November	11/08/2011	11/09/2011
	December	12/06/2011	12/07/2011
2012	January	01/03/2012	01/04/2012
	February	02/07/2012	02/08/2012
	March	03/06/2012	03/07/2012
	April	04/03/2012	04/04/2012
	May	05/08/2012	05/09/2012
	June	06/05/2012	06/06/2012
	July	07/03/2012	07/05/2012
	August	08/07/2012	08/08/2012
	September	09/04/2012	09/05/2012
	October	10/02/2012	10/03/2012
	November	11/06/2012	11/07/2012
	December	12/04/2012	12/05/2012
2013	January	01/08/2013	01/09/2013
	February	02/05/2013	02/06/2013
	March	03/05/2013	03/06/2013
	April	04/02/2013	04/03/2013
	May	05/07/2013	05/08/2013
	June	06/04/2013	06/05/2013
	July	07/02/2013	07/03/2013
	August	08/06/2013	08/07/2013
	September	09/03/2013	09/04/2013
	October	10/08/2013	10/09/2013
	November	11/05/2013	11/06/2013
	December	12/03/2013	12/04/2013
2014	January	01/07/2014	01/08/2014
	February	02/04/2014	02/05/2014
	March	03/04/2014	03/05/2014
	April	04/08/2014	04/09/2014
	May	05/06/2014	05/07/2014
	June	06/04/2014	06/05/2014

APPENDIX Y

CCN Network Provider Contractor Listing Spreadsheet Requirements

CCN NETWORK PROVIDER CONTRACTOR LISTING SPREADSHEET REQUIREMENTS

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

1. Practitioner Last Name, First Name and Title - For types of service such as primary care providers and specialist, list the practitioner's name and practitioner title such as MD, NP (Nurse Practitioner), PA (Physician Assistant), etc.

2. Practice Name/Provider Name - Indicate the name of the provider. For practitioners indicate the professional association/group name, if applicable.

3. Business Location Address - Indicate the business location address where services are provided including but not limited to, 1st line of address, 2nd line of address, City, State, Postal Code and Telephone Numbers (office and fax).

4. License Number - Indicate the provider/practitioner license number, if appropriate.

5. Medicaid Provider Number – Indicated the provider/practitioner's Medicaid provider number, if they are a Medicaid provider.

6. Provider Type and Specialty Code - Indicate the practitioner's specialty using the attached Medicaid Provider Type and Specialty Codes.

7. New Patient - Indicate whether or not the provider is accepting new patients.

8. Age Restriction - Indicate any age restrictions for the provider's practice. For instance, if a physician only sees patients up to age 19, indicate < 19; if a physician only sees patients age 13 or above, indicate ≥ 13.

9. Contract Name/Number – Indicate which CCN subcontract the physician is associated with. Example: If the contract is for a group practice, all physicians within the group will have the same contract name/number.

10. Contract Begin Date – Indicate the date the contract became effective.

11. Contract Termination Date – Indicate the date the contract ended.

12. Parish Served – Indicate which parish or parishes the provider serves. Do so by listing all 64 parishes in alphabetical order (one column per parish) and placing an "X" in each appropriate column, indicating that the provider serves that parish. For example, if the provider has offices in 3 parishes, but is used by the CCN to provide services in 6 parishes, place an "X" in the columns of each of the 6 parishes served.

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

Appendix Z
Marketing Complaint Form

DEPARTMENT OF HEALTH AND HOSPITALS
Medicaid

Louisiana Coordinated Care Network Program

Marketing Complaint Form

FOR DHH USE ONLY	
STAGE OF REVIEW	DATE
☐ *Form Received at DHH*	
☐ *Investigation Begins*	
☐ *Sanctions Applied*	
☐ *Response Sent to Complainant*	
☐ *Investigation Closed*	

COMPLAINANT CONTACT INFORMATION

Complainant Name/ Title/Organization:

Address:

Phone:	**E-mail:**	**Fax:**

COMPLAINT DETAILS

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

Date/Time/Frequency of Alleged Violation:

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

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

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

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

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

DHH INVESTIGATION NOTES

DHH Investigator Signature:
(at completion of investigation)

Print Name:	**Date:**

Appendix AA
Marketing Event Submission Form

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

DEPARTMENT OF HEALTH AND HOSPITALS
Medicaid

Louisiana Coordinated Care Network Program

Marketing Event Submission Form

COORDINATED CARE NETWORK CONTACT INFORMATION

CCN Name/ Name of Person Submitting/ Title:		
Address:		
Phone:	**E-mail:**	**Fax:**

EVENT HOST INFORMATION

Event Host Organization or Business:	**Event Host Contact:** *(Name and Title)*
Event Host Phone Number:	**Event Host E-mail:**

EVENT DETAILS

Name of Event:	**Date of Event:**	**Time of Event:**

Event Location: *(City, Parish and DHH Region)*	**Type of Event:** ☐Presentation ☐Community Event ☐Health Fair ☐Other: _____

Target Audience for Event:
☐Members ☐Providers ☐General Public ☐Other: _____

Brief Description of Event:

Marketing Materials to be Distributed at Event:

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

DHH RESPONSE

Approval Response: ☐ Event Approved ☐ Event Not Approved ☐ Further Detail Needed	**Additional Details Needed:**

DHH Signature:

Date:

Appendix BB
Marketing Material Submission Form

FOR DHH USE ONLY	
Submitted for *(choose one)*	Review ☐
	Approval ☐
Date Submitted by CCN	
Date of DHH Response *(see below for response)*	

DEPARTMENT OF HEALTH AND HOSPITALS
Medicaid

Louisiana Coordinated Care Network Program

Marketing Materials Submission Form

COORDINATED CARE NETWORK CONTACT INFORMATION

CCN Name/ Name of Person Submitting/ Title:		
Address:		
Phone:	**E-mail:**	**Fax:**

MARKETING MATERIAL DETAILS

Name of Marketing Material:

Type of Marketing Material (check one):

☐Print Ad ☐Radio Ad ☐TV Ad ☐Billboard ☐Flyer ☐Newsletter ☐News Release ☐Poster ☐Bus board ☐Website
☐Promotional Item ☐Phone Script ☐Brochure ☐Sign ☐Handbook ☐Directory ☐ Other: _____

Purpose or Goal of the Marketing Material:

DISTRIBUTION PLAN FOR MARKETING MATERIAL

Target Audience for Marketing Material:
☐Members ☐Providers ☐General Public ☐Other: _____

Quantity or Impressions: *(number of materials to be printed/distributed or in the case of broadcast, the number of planned impressions)*

Distribution Plan for Marketing Material: *(should illustrate equitable distribution plan for the service area – attach additional pages as needed)*

Map or explanation of service area attached: ☐	**Media Buy Documentation Attached:** ☐

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

DHH RESPONSE

First Draft ☐ Make changes and return to DHH ☐ Approved with changes ☐ Approved for printing/publication	**First Draft** ☐ Make changes and return to DHH ☐ Approved with changes ☐ Approved for printing/publication	**First Draft** ☐ Make changes and return to DHH ☐ Approved with changes ☐ Approved for printing/publication
DHH Signature:	**DHH Signature:**	**DHH Signature:**
Date:	**Date**	**Date:**

Appendix CC
OPH/CCN Memorandum of Understanding

Office of Public Health Memorandum of Understanding Guidelines

The CCN will coordinate its public health-related activities with the Louisiana Office of Public Health (OPH). Coordination mechanisms and operational protocols for addressing public health issues will be negotiated with OPH and BHSF (Medicaid) and reflect Louisiana public health priorities. The coordination of activities related to public health will take the form of agreements among the parties which may include policy memos or separate memorandums of understanding signed by OPH, BHSF (Medicaid), and the CCNs. Public health-related activities include, but are not limited to:

- Sexually transmitted diseases
- Human immunodeficiency virus (HIV/AIDS) prevention and treatment
- Tuberculosis
- Immunization
- WIC (Supplemental Nutrition Program for Women, Infants, and Children)
- Family planning
- Maternal and child health (MCH)
- Children's Special Health Services (Louisiana's program for children with special health care needs)
- Population-based services

MOU's will cover the following topics with regard to the public health activities:

- Statement of common goals, priority populations and conditions and measurable objectives
- Inter-organizational communication protocols
- Data sharing and reporting
- Coordination of outreach and education
- Population health assessments
- Case management for high-risk populations (TB, HIV/AIDS, STD, NFP)

- Technical assistance
- Special projects (e.g., mutual pursuit of grants)
- Attachment: List of public health resources in region and identification of those that are "in network"