

Community Health Solutions of Louisiana (CHS-LA)
CCN-S Proposal Submission
Geographic Service Area: A, B, C

Section J: **Quality Management (Section 7 of RFP)**

Requirement J.1: *Document experience in other States to positively impact the healthcare status of Medicaid and or CHIP populations. Examples of areas of interest include, but are not limited to the following:*

- *Management of high risk pregnancy*
- *Reductions in low birth weight babies*
- *Pediatric Obesity (children under the age of 19)*
- *Reduction of inappropriate utilization of emergent services*
- *EPSDT*
- *Children with special health care needs*
- *Asthma*
- *Diabetes*
- *Cardiovascular diseases*
- *Reduction in racial and ethnic health care disparities to improve health status*
- *Hospital readmissions and avoidable hospitalizations*

Response:

Community Health Solutions of America (CHS), through its South Carolina based program, South Carolina Solutions (SCS), continues to positively impact the healthcare status of South Carolina Medicaid Members through our quality management programs as demonstrated by the South Carolina Medicaid Health Plans Report Card issued in October, 2010 (based on calendar year 2009 data). The South Carolina Department of Health and Human Services (SCDHHS) contracted with the Institute for Families in Society (IFS) at the University of South Carolina to provide an independent evaluation of performance and consumer satisfaction measures for each of the Medicaid health plan. IFS utilized a NCQA certified survey vendor and software to calculate performance scores on the Health Plan Report Card. The results of this report card indicate the positive impact SCS has had on the health status of SC's Medicaid population.

1. Staying Healthy- Children Results:
 - Highest number of measures exceeding the National 75th percentile, those measures included:
 - Annual dental visits: total (Ages 2-21).
 - Child and adolescent access to primary care (ages 12-24 months).

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- Well-child visits (ages 0 through 15 months).
- 2. Staying Healthy- Adults Results:
 - Only health plan exceeding National average in Breast Cancer screening.
 - Measures scoring above National average for:
 - Adult access to preventive ambulatory health services (ages 20-44).
 - Postnatal care visits.
- 3. Living with Illness and Disability Results:
 - Exceeded National average in the following measures:
 - Asthma: appropriate medication use (ages 5-9).
 - Asthma: appropriate medication use (ages 10-17).
 - Diabetes care: dilated eye exam (%Members ages 18-75)
 - Exceeded National average for diabetes care: urine screening.
- 4. Behavioral Health Results:
 - Exceeded National average for the following measures:
 - Follow-up care within seven (7) days after hospitalization for mental illness (ages 6 and above).
 - Follow-up care within 30 days after hospitalization for mental illness (ages 6 and above).
- 5. Accessing Healthcare: Consumer Satisfaction:
 - Exceeded National average for getting needed care: Child
 - Met National average for:
 - Getting needed care: Adult
 - Getting care quickly: Adult
 - Getting care quickly: Child

Currently, SCS, along with all other Medicaid health plans and SCDHHS, is participating in a statewide quality improvement initiative to improve the health of South Carolina's Medicaid Members with Asthma. Goals of the Asthma performance improvement project include:

- Standardized quantitative and qualitative performance measure development and reporting.
 - Identification and implementation of system interventions to achieve process and performance improvement.
 - Evaluation of effectiveness of designed interventions.
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- Planning and initiation of activities to increase and / or sustain improvements.

Positive impact has been demonstrated through our Emergency Room(ER) quality improvement project (QIP). This QIP was focused on reducing inappropriate ER utilization; encouraging appropriate and timely utilization of PCP for prevention and non-emergent care; and encouraging PCPs to maintain urgent care appointment times on their schedules to avoid inappropriate ER referrals. ER utilization data is evaluated monthly to identify Members who would benefit from outreach. Outreach was designed as a multi-level process including:

- Development of ER “high flier” work queue for clinical outreach by dedicated Care Management Registered Nurse (RN).
- Automated educational mailing for high-volume diagnoses which include tips on prevention, reinforcement of 24/7 Nurse Line and importance of establishing relationship with PCP.
- Blaster calls to remind Members to schedule appointment with PCP.
- Monthly PCP reports to demonstrate Member population ER utilization.
- Quarterly ER utilization data is provided to the PCP which compares their Members’ ER use to regional and SCS aggregate benchmarks.

Since project implementation in January 2006, ER utilization has shown some fluctuation, but has decreased overall from a high of 77 visits per 1000 Members per month to an average of 55.25 visits per 1000 Members per month.

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Requirement J.2: *Describe how you will identify quality improvement opportunities. Describe the process that will be utilized to select a performance improvement project, and the process to be utilized to improve care or services. Include information on how interventions will be evaluated for effectiveness. Identify proposed members of the Quality Assessment Committee.*

Response: Community Health Solutions of Louisiana (CHS-LA) has a continuous quality improvement process to assist in identifying quality improvement opportunities. CHS-LA’s Quality Management Program (QMP) is a planned, systematic, organization wide approach of monitoring, analysis and improvement focused on continually improving the quality of care and services delivered to our Members.

Quality improvement opportunities are identified through analysis of quality performance measurement data obtained from various sources including:

- Claims data.
- Pharmacy data.
- Utilization review data.
- Member and provider satisfaction surveys.
- Member and provider complaint data.
- Access and availability data.
- Appeals and grievance information.
- Statistical, epidemiological, and demographic member information.
- Authorization and referral data.
- Enrollment data.
- Outreach data.
- Internal audit data.
- Delegated contractor quality reporting.
- Clinical outcomes data.
- Admission and re-admission data.
- Program effectiveness data, including case management and disease management programs.
- Operational performance evaluation.
- Compliance program data.

CHS-LA’s Executive Committee has direct oversight of the QMP and prioritizes selection of Performance Improvement Projects (PIP) based

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on the degree to which the PIP:

- Addresses state, federal or accreditation compliance requirements.
- Addresses client directed or contractual requirement.
- Addresses high-volume, high-risk or problem prone processes.
- Addresses organizational strategic goals.
- Is vital to the development and implementation of new programs, processes or systems.
- Has potential for meaningful improvement.
- Has potential for significant sustained improvement.
- Is likely to achieve improvements within a reasonable length of time.
- Affects members with special health care needs.
- Reflects the population in terms of age, disease prevalence, or special risk status.
- Is linked to outcomes that are definable.
- Is linked to evidence-based design and intervention.
- Is linked to Clinical care guidelines or practice standards relevant to the project that are available.
- Is linked to available benchmark data for comparison analysis.
- Is linked to resources that are available for project implementation.
- Is linked to valid, reliable data that is available for analysis.
- Is linked to definable and measurable performance measures.

Once an improvement opportunity is identified and prioritized, a planned, systematic, data driven approach is used to improve care and services. A collaborative interdepartmental performance improvement team, approved by executive leadership and directed by quality management will implement the performance improvement process using the Plan-Do-Study-Act (PDSA) model for continuous improvement as outlined below:

- PLAN- the necessary action steps;
- DO - all that is necessary to implement the action plan as pilot and collect data to evaluate effectiveness;
- STUDY- the results for the desired outcome; and
- ACT - to fully implement the improvement or rework the PDSA cycle as necessary to make further changes and sustains the improvements.

The PDSA model allows for intensive analysis of the particular process, treatment, service or aspect of care by qualified staff in key functional departments.

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Development and collection of objective and definable performance measures allows for evaluation of effectiveness of the designed interventions. Analysis of data in comparison to established benchmarks, when available, and outcome objectives provide additional insight into the effectiveness of the interventions.

As a result of continuous data monitoring and evaluation, planned interventions are fully implemented or re-designed for continued evaluation until sustained improvement is evident and established goals achieved.

Results of PIPs are reported by the quality management participant to the Quality Assessment Committee (QAC) whose proposed membership for CHS-LA would include:

- CHS President and Chief Medical Officer
- CHS Vice President of Clinical and Quality Operations
- CHS-LA Medical Director(s)
- CHS-LA Compliance Officer
- CHS-LA Grievance Systems Manager
- CHS-LA Quality Management Coordinator
- CHS-LA Member Services Manager
- CHS-LA Provider Services Manager
- CHS-LA Claims Service Manager
- CHS-LA Information Systems Manager
- CHS-LA Care Management Manager
- CHS Human Resources Manager
- Ad-hoc departmental representatives

The QAC will report directly to Executive Committee who, as indicated above, has ultimate authority and oversight over the organizational QMP.

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Requirement J.3: *Provide a description of focus studies performed, quality improvement projects, and any improvements you have implemented and their outcomes. Such outcomes should include cost savings realized, process efficiencies, and improvements to member health status. Such descriptions should address such activities since 2001 and how issues and root causes were identified, and what was changed.*

Response: Community Health Solutions of America (CHS), through its South Carolina based program, South Carolina Solutions (SCS), has conducted multiple focus studies and quality improvement projects resulting in process improvements and improved Member outcomes. Descriptions of four (4) SCS projects are provided below.

1. To assess the adequacy of after-hours access to clinical services to our Members, SCS carried out an evaluation from February 2007 through February 2009. Member Services staff members placed calls to each contracted PCP office after the office's normal hours of operation to evaluate its after-hours referral process.

Initial results indicated that fifty-two per cent (52%) of PCP offices appropriately referred Members to SCS's 24/7 Nurse Line for clinical services. To improve these results, SCS implemented the following performance improvement actions:

- Feedback was provided to PCPs regarding accessibility results, along with education to improve compliance.
- Reminders to refer Members to SCS' 24/7 Nurse Line for clinical services after normal office hours were included in our monthly Provider Newsletter.
- A magnet providing contact information for our 24/7 Nurse Line was included in Members' Welcome Packets.
- Care Management and Member Services staff were instructed to reinforce utilization of the 24/7 Nurse Line when communicating with Members.

As a result of these interventions:

- PCP referrals to the Nurse Line increased to eighty per cent (80%) during the 2009 evaluation.
 - Emergency room Per Member, Per Month (PMPM) costs decreased from an average of \$18.28 in 2007 to an average of \$15.93 in 2009.
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2. Population data analysis indicated a high prevalence of Asthma in the South Carolina population. To improve the provision of health care to SCS Members with Asthma, we developed an internal quality improvement project. The project team analyzed claims data to identify specific improvement opportunities, which included:

- Need for improved medication management.
- Need for increased outreach to Members with Asthma for disease education and management.
- Need for utilization of zone management plan.
- Need for Members to establish on-going relationship with PCP.

The following interventions were implemented:

- An Asthma specific work queue was established for clinical outreach.
- Additional staff members were hired to adequately outreach to the volume of Asthma members.
- Zone management plan was incorporated into disease education and care planning.
- Partnerships were developed with community and hospital based disease management programs.
- Staff participated in statewide initiatives to improve health outcomes for individuals with Asthma.

As a result of these interventions, the following improvements have been recognized:

- A 15% increase of participation in Care Management program by Members with Asthma.
- A statistically significant improvement in appropriate use of medication (increased from 65.8% to 74%).

3. Monitoring of Member PCP transfer data indicated a 15.5% increase in transfer volume from 2009 to 2010. Our goal in evaluating the member transfer process was to identify areas for workflow efficiency and timely / accurate transfer of members to a new Medical Home Provider. Initial evaluation of the process indicated:

- Multi-step, labor intensive process design with a Member transfer error rate of nine per cent (9%).

Interventions taken for improvement based on result of analysis included:

- Re-design of our workflow and transfer process.
 - Partnering with our information systems team to develop an efficient electronic process.
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- Implementation of an electronic direct entry tool that automated the reporting of member transfer data to the state.
- Staff training regarding process changes prior to implementation.

The outcome of above intervention included:

- Member transfer error rate decreased from nine percent (9%) in March 2010 to point nine per cent (0.9%) in March 2011.
- SCS staff time was reallocated. Due to process efficiencies, dedicated staff decreased by half, allowing those resources to be utilized in other areas.

4. In November, 2010 the FDA recalled Darvon due to patient safety risks. Based on this recall, SCS evaluated all pharmacy data for the prior six (6) months to identify Members who had been prescribed Darvon.

With the approval of our South Carolina Peer Review Committee (PRC), the quality department sent an educational letter, along with supporting FDA documentation, to the sixteen (16) PCPs who had prescribed Darvon within the prior six (6). Claims data for members who had been prescribed Darvon continued to be evaluated for an additional six (6) months with no adverse outcomes identified.

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Requirement J.4: *Describe your proposed Quality Assessment and Improvement Program (QAPI). Such description should address:*

- *The QAPIs proposed to be implemented during the term of the contract.*
- *How the proposed QAPI s will expand quality improvement services.*
- *How the proposed QAPI will improve the health care status of the Louisiana Medicaid population.*
- *Rationale for selecting the particular programs including the identification of particular health care problems and issues identified within the Louisiana Medicaid population that each program will address and the underlying cause(s) of such problems and issues.*
- *How your will keep DHH informed of QAPI program actions, recommendations and outcomes on an ongoing and timely manner.*
- *How the proposed QAPIs may include, but is not necessarily, limited to the following:*
 - *New innovative programs and processes.*
 - *Contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts and/or School Based Health Clinics.*

Response:

Community Health Solutions of Louisiana (CHS-LA) proposes an organization wide Quality Assessment and Performance Improvement (QAPI) program focused on improving health outcomes. This will be accomplished through a systematic, objective, data driven approach to:

- Ensure appropriate care and services is provided to all enrolled Members.
 - Improve Member health outcomes.
 - Implement process efficiencies, both clinical and operational.
 - Monitor physician performance.
 - Detect under- and overutilization of services.
 - Ensure effective utilization of services.
 - Identify performance improvement opportunities.
 - Develop and implement performance improvement projects.
 - Minimize risk to Members and the organization.
 - Evaluate cost effectiveness of program services.
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After successful implementation of our initial QAPI, CHS-LA anticipates expanding our quality improvement services through collaboration with DHH and other health plan entities to develop statewide quality initiatives. Community Health Solutions of America(CHS), through its South Carolina based program, South Carolina Solutions (SCS), is currently participating in a statewide quality improvement initiative focused on improving health care outcomes, while controlling health expenditures, for South Carolina Medicaid Members with Asthma.

CHS-LA's QAPI will improve health care status of the Louisiana Medicaid population through:

1. Implementation and evaluation of our Care Management programs for:
 - Chronic / complex conditions, including:
 - Cardiovascular disease (includes hyperlipidemia and obesity management)
 - Pulmonary disease
 - Endocrine (includes hyperlipidemia and obesity management)
 - Diabetes, Type I and Type II (adult and pediatric)
 - Hematological (sickle cell anemia)
 - Maternity (including wellness education and high risk)
 - EPSDT and immunization
 - Infant / toddler growth and development
2. Continuous monitoring and evaluation of program performance measurement data to identify improvement opportunities in key areas including:
 - Physician performance
 - Prevention and wellness
 - Access and availability
 - Effectiveness of care
 - Service utilization
 - Member and provider program satisfaction
 - Health outcomes

CHS-LA selects Care Management programs based on:

- Prevalence of disease or condition within the population being served.
 - Availability of evidence based clinical practice guidelines and scientific methodology to improvement clinical outcomes through
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- management or prevention of disease.
- Contractual or regulatory requirements.

The 2009 Louisiana Health Report Card indicates a high prevalence of:

- Cardiovascular disease.
- Diabetes.
- Asthma.
- Infant mortality.

Care Management programs address underlying causes of these conditions, such as:

- cholesterol level
- nutritional status/obesity
- smoking
- substance abuse
- stress factors/risk factors
- exercise
- blood pressure and glucose monitoring
- pre-natal visits
- immunization

through Chronic Care/ Disease Management education programs, Care Coordination efforts and referral to community resources. The QAPI monitors and analyzes data reflective of these chronic and/or high risk conditions to evaluate program effectiveness and identify program or process improvement opportunities.

When improvement opportunities are recognized, interdisciplinary performance improvement teams are established for in-depth evaluation and root cause analysis of performance measures. Improvement interventions will be determined based on this analysis. Interventions to improve health outcomes may include:

- Re-design of established program or process.
- Implementation of a new program or process.
- Partnership with community resources to improve health outcomes.
- On-site screening and education services such as flu clinics, blood pressure and glucose monitoring.
- Physician education regarding condition-specific services.

Results of QAPI program monitoring, effectiveness and corrective action plans will be captured by CHS-LA on a monthly, quarterly and/or annual basis and reported to DHH as outlined in the reporting requirements of the RFP.

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Section J: **Quality Management (Section 7 of RFP)**

Requirement J.5: *Describe how feedback (complaints, survey results, CCN Consumer/Provider Committee, etc.) from members and providers will be used to drive changes and/or improvements to your operations. Provide a member and a provider example of how feedback has been used by you to drive change in other Medicaid managed care contracts.*

Response: Community Health Solutions of Louisiana (CHS-LA) will use Member and provider feedback to identify improvement opportunities. Analysis of results and feedback from providers or Members will be used to drive change/improvements in our organizational operations to:

- Enhance patient-centeredness of care.
- Improve quality of care delivery.
- Improve Member and provider experience.
- Improve communication with Member and provider committees.
- Improve/enhance Member and provider educational materials.
- Improve coordination with community-based resources.

An example of using Member feedback to drive change comes from Community Health Solutions of America’s (CHS) South Carolina based Asthma program. Claims triggers identified Members with Asthma for outreach. Evaluation of claims data indicated opportunities for Care Management intervention and our Registered Nurse (RN) Care Manager, assigned to Members with Asthma, telephonically contacted the Member. After the RN Care Manager explained her role, the Member expressed confusion stating she was already receiving education and disease management services from her physician. To prevent confusion and duplication of services, CHS and the hospital system where this Member’s PCP worked developed a coordinated, collaborative approach to managing Asthma among individuals jointly served by our two organizations. Through this collaborative effort, a coordinated, systematic exchange of information between Care Managers, Members and physicians was achieved and services were not duplicated.

An example of using physician feedback to drive change comes from direct communication with a contracted physician who received a Care Plan from a Registered Nurse (RN) associated with our South Carolina program. The physician communicated concerns that evaluation data

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to formulate the patient-centered Care Plan were not evident. As a result, a comprehensive Care Plan packet of information is now generated and sent to all PCPs, along with the Care Plan. This packet includes:

- Health Risk Assessment (HRA)
- Disease Specific Assessment (DSA)
- Psychosocial evaluation
- Functional or behavioral risks
- Environmental risks
- Nutritional and exercise evaluation
- Medication assessment

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Section J: **Quality Management (Section 7 of RFP)**

Requirement J.6: *Provide, in Excel format, the Proposer's results for the HEDIS measures specified below for the last three measurement years (2007, 2008, and 2009) for each of your State Medicaid contracts.*

- *If you do not have results for a particular measure or year, provide the results that you do have.*
- *If you do not have results for your Medicaid product line in a state where you have a Medicaid contract, provide the commercial product line results with an indicator stating the product line.*
- *If you do not have Medicaid HEDIS results for at least five states, provide your commercial HEDIS measures for your largest contracts for up to five states (e.g., if you have HEDIS results for the three states where you have a Medicaid contract, you only have Medicare HEDIS for one other state, provide commercial HEDIS results for another state).*
- *If you do not have HEDIS results for five states, provide the results that you do have.*
- *In addition to the spreadsheet, please provide an explanation of how you selected the states, contracts, product lines, etc. that are included in the spreadsheet and explain any missing information (measure, year, or Medicaid contract). **Include the Proposer's parent organization, affiliates, and subsidiaries.***

Provide results for the following HEDIS measures:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Comprehensive Diabetes Care- HgbA1C component*
- *Chlamydia Screening in Women*
- *Well-Child Visits in the 3,4,5,6 years of life Adolescent well-Care.*
- *Ambulatory Care - ER utilization*
- *Childhood Immunization status*
- *Breast Cancer Screening*
- *Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care)*
- *Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents*

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Response:

Community Health Solutions of Louisiana (CHS-LA) has attached a spreadsheet which provides HEDIS measures calculated by the Institute for Families in Society (IFS) on behalf of the South Carolina Department of Health and Human Services (SCDHHS). IFS is housed within the University of South Carolina's Arnold School of Public Health. IFS has a long-standing contract with SCDHHS, one component of which is calculating HEDIS results, based on administrative data, for all of the Medicaid managed care plans. Due to the timing of enrollment of Members who are eligible based on their pregnancy, the Pre-natal measures are not reflective of our care management processes. Measurement for weight assessment and counseling for nutrition requires a hybrid medical record review to accurately reflect physician level performance and, therefore, is not available. CHS-LA has incorporated BMI assessment, nutritional and exercise counseling into all care management programs.

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Requirement J.6: *Provide, in Excel format, the Proposer's results for the HEDIS measures specified below for the last three measurement years (2007, 2008, and 2009) for each of your State Medicaid contracts.*

Attachment 1: HEDIS Measures – Measurement Years 2007, 2008, and 2009

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**HEDIS Measures Results
Years 2007 - 2009**

	A	B	C	D
1				
2	HEDIS Measure Year	2007	2008	2009
3	Adult Access to Preventive / Ambulatory Health Services (AAP)			
4	Overall Rate	21%		76%
5	Comprehensive Diabetes Care - HgbA1c (CDC)	74%	57%	55%
6	Breast Cancer Screening (BCS)	43%	45%	47%
7	Well Child Visits in the 3, 4, 5, and 6th Years of Life (W34)	42%	42%	48%
8	Adolescent Well Care (AWC)	21%	24%	27%
9	Ambulatory Care - ER Utilization	Visits / 1000 Member Months		
10	Ages < 1	103	108	113
11	Ages 1-9	61	59	57
12	Ages 10-19	56	53	51
13	Ages 20-44	132	157	147
14	Ages 45-64	101	124	109
15	Ages 65-74	29	69	59
16	Ages 75-84	25	54	45
17	Ages 85+	35	62	48
18	Childhood Immunization - Ages < 2			
19	1 Immunization Vaccine		13%	4%
20	2 Immunization Vaccines		14%	8%
21	3 Immunizations Vaccines		7%	31%
22	4 or More Vaccines		30%	12%
23	Breast Cancer Screening			
24	Percentage of women 40-69 who had mammogram	43%	45%	47%
25	Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care)			
26	Prenatal Care		80%	
27	Postnatal Care		62%	
28	Weight Assessment and Counseling for Nutrition and Physical Activity in Children / Adolescents - Nutrition			
29	Age 3 - 11 Years			0.0014%
30	Age 12 - 17 Years			0.0019%
31	Weight Assessment and Counseling for Nutrition and Physical Activity in Children / Adolescents - Physical Activity			
32	Age 3 - 11 Years			0.0%
33	Age 12 - 17 Years			0.0%
34	The above HEDIS measures are from a single state where Community Health Solutions of America have a Medical Home Network contract with 130,000 enrollees. The Institute for Families in Society 2007, 2008 and 2009 HEDIS Reports specific to our organization were used to build this table. The darker shaded cells were not measured in the timeframe required by the table. Several HEDIS measures were monitored that were not requested for this report.			
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Section K: **Member Materials (Section 11 of RFP)**

Requirement K.1: *Describe proposed content for your Member educational materials) and attach examples used with Medicaid or CHIP populations in other states.*

Response: Community Health Solutions of Louisiana (CHS-LA) will develop all Member materials with the understanding that they must be accurate and, regardless of format in which they are presented, must be approved by DHH prior to use. CHS-LA also understands that our Member materials must be available in various languages and formats to ensure accessibility. These materials encompass everything from: (1) CHS-LA Welcome Packet pieces that help a person better understand their rights and responsibilities as a Member of our plan and how to get the most from their health plan, to (2) information on the value and use of health screening tools , to (3) Disease Management modules that can augment the understanding of personal health care needs and decisions when partnering with medical providers, to (4) blaster calls to educate and remind Members about preventive services.

CHS-LA proposes the following basic content for the Member Welcome Packet:

- Member Welcome Letter
- Brochure Describing an Overview of CHS-LA CCN-S Plan Services
- CHS-LA Member Handbook
- Overview of Member Rights and Responsibilities
- HIPAA Privacy Rights
- All pertinent and required contact numbers and website information including, but not limited to:
 - Member Services department
 - Care Management department
 - Complaint reporting
 - Enrollment Broker Services
 - 24/7 Nurse Line
- CHS-LA Member Card, with Member’s name on front. CHS-LA shall stress the importance of ensuring information on card is correct and the importance of taking the CHS-LA Member Card to medical appointments.
- A list of appropriate providers within their geographic area (i.e.

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accepting new Members, serve Member's age group, provide women's health services, if applicable)

- Tips for Making the Most of PCP Visits, to include:
 - Making a list of health needs/questions prior to the appointment
 - Knowing the names and addresses of past health care providers
 - Sharing health history with new doctor
 - Taking current medications and prescriptions to medical appointments
 - Being on time for appointments
 - Taking children in for well-child visits and immunizations
- CHS-LA will also provide Members with the following informational items:
 - Brochure entitled, "Tips for Choosing a Primary Care Physician (PCP)/Clinic."
 - Brochure for parents/caregivers on the "The Importance of Well-Child Visits and Keeping Immunizations Up-to-Date."
 - Health Risk Assessments/Tools for Member to complete and provide to CHS-LA, if so desired.

Samples of South Carolina Solutions welcome letter and brochure are attached.

CHS-LA proposes that our Disease Management education materials include the following information:

- Definitions of medical terms, written at a sixth (6th) grade level or below, to help support understanding of disease and increase health literacy.
- When to contact the doctor or seek emergency assistance.
- An overview of the specific disease (i.e. Sickle Cell).
- Symptoms, including acute symptoms.
- Potential complications.
- Diagnostic testing that may be associated with the disease.
- Prevention of symptoms, exacerbation or complications.
- Nutrition, safety and exercise.
- Coping strategies and support.
- Treatments associated with the disease.
- Medications and vaccinations (as applicable).
- Resource information for caregivers.
- Travel reminders.

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Several pages from CHS Disease Management modules are attached. These include "Understanding Asthma" and "Understanding Sickle Cell".

Several pages from our Maternity Program materials, "Before I Was Born" maternity calendar, are also included.

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Section K: **Member Materials (Section 11 of RFP)**

Requirement K.1: *Describe proposed content for your member educational materials) and attach examples used with Medicaid or CHIP populations in other states.*

Attachment 1: Sample South Carolina Solutions Welcome Letter

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Welcome to the South Carolina Solutions Medical Homes Network Program.

Date

«Name»
«Address1»
«Address2»
«City», «ST» «Zip»

Dear Member:

South Carolina Solutions is a Medical Homes Network (MHN) Program. We work with “South Carolina Healthy Connections” to provide Medicaid beneficiaries with services that help them understand and take good care of their health. Together with your primary care or Medical Home doctor, who has also joined our program, we will help you get the medical care you need.

The people in your family listed below are now in the South Carolina Solutions MHN program:

<u>Family Member:</u>	<u>Medical Home:</u>	<u>Medical Home Phone:</u>
«Member1»	«MH1»	«MHPhone1»
«Member2»	«MH2»	«MHPhone2»
«Member3»	«MH3»	«MHPhone3»
«Member4»	«MH4»	«MHPhone4»
«Member5»	«MH5»	«MHPhone5»
«Member6»	«MH6»	«MHPhone6»
«Member7»	«MH7»	«MHPhone7»
«Member8»	«MH8»	«MHPhone8»
«Member9»	«MH9»	«MHPhone9»

If you are a new patient with this doctor, please call them within the next 30 days to schedule a visit which will establish you or your family members as patients with their office.

South Carolina Solutions is NOT a MCO or HMO. So, as a member of South Carolina Solutions you will not have to change specialty doctors, OB doctors or change your medicines unless you and your doctor decide that this is right for you. Also, you will get all of the same benefits as Medicaid Fee for Service *plus* the great additional benefits listed below:

- Your primary care or Medical Home doctor will care for you.
- UNLIMITED doctor visits for adult members. Be sure to get your Medical Home doctor’s okay before going to another doctor.
- With your Medical Home doctor’s okay, you can be treated by any specialist, health care provider or hospital that accepts Medicaid.
- No more copays to your doctors or for your medicines.
- You can get the same medicines on our program as you can get on Medicaid Fee for Service.
- You will get help from your doctors and our nurses if you need to see specialty doctors for your health conditions.
- Disease education is offered to help you understand and better take care of your medical problems such as asthma, diabetes, or high blood pressure.
- Pregnant members have access to a special program to help you deliver a healthy baby!
- You can call our 24 hour Nurse Help Line when you have questions about your or your family’s health if your doctor’s office is busy or closed. The toll-free number is 1-888-366-6243 then press option #2

IF YOU ARE PREGNANT, YOU CAN STAY WITH YOUR OB DOCTOR BY HAVING THEM CALL YOUR NEW MEDICAL HOME DOCTOR TO GET THE OKAY.

We have nurses who will work with you and your doctor. One of our nurses may be calling you to ask you questions and to offer you help. The nurse’s job is to help you get the care you need.

Please call toll-free 1-888-366-6243 and then press option # 4 to tell us if you are pregnant or if you would like to talk to a nurse for other reasons. Please be sure to always carry your “South Carolina Healthy Connections” Medicaid ID card and show the card when you go to your doctor for medical care. That way they will know you are a member of the program. On the back of this letter is more information about South Carolina Solutions. If you still have questions after reading this or you would like a new Member Handbook, call your doctor or stop by their office. You may also call us toll-free at South Carolina Solutions, 1-888-366-6243, Option 1 between the hours of 8am and 5pm Monday thru Friday. We will gladly help you.

Wishing you good health!
South Carolina Solutions Staff



QUESTIONS and ANSWERS

What is South Carolina Solutions?

South Carolina Solutions is a Medical Home Network program not an HMO. We work with South Carolina Healthy Connections to offer you more services! In addition to all of the same benefits you would receive under Medicaid Fee for Service you will have all of the great additional benefits listed below:

- A Medical Home of your choice
- Access to medical care 24 hours a day 7 days a week
- Unlimited services for children
- Unlimited doctor visits for adult members
- No Copayments for medical care
- A Care Coordination nurse available to you and your doctor
- Access to Disease Management and Education
- Access to the 24-Hour Nurse Help Line

These Services Are FREE!

What is a Medical Home?

A Medical Home is a doctor's office where you can go to get medical care. You no longer need to go to the emergency room for common illnesses. Be sure to get your doctor's okay before going to another doctor.

What is Care Coordination?

Care Coordination is a service that provides a nurse that you can talk to by telephone. The nurse will be able to answer questions you may have about your health or medical care, explain tests, and work with you and your doctor to help manage your illness or your pregnancy.

What is Disease Management and Education?

Disease Management and Education are services that may have a nurse call you and send you information that will help you to understand and better manage your chronic illness. The nurse will also work with your doctor to put together a plan of care for you and help you get the care you need. You can call the nurse if you have questions about your care plan and to ask any questions you may have about your illness.

How does the Program work?

You will be contacted by telephone or mail so that a Health Risk Assessment can be completed.

This is simple! When one of our nurses calls you, you will just answer some basic questions about your illness. Based on your answers, our nurse may talk to you about how Care Coordination, Disease Management or Disease Education may help improve your health.

Our nurse will always work with your Medical Home doctor to develop your plan of care and keep your doctor informed on your progress. Our nurse and your Medical Home doctor will also help you get care from other doctors or specialists, if needed.

Complaints

Any concerns about your care, access to doctor or dissatisfaction with the Medical Home Program is important. South Carolina Solutions aims to resolve your concerns as quickly as possible and wants you to tell us so that we can make our program even better. You may file a complaint verbally or in writing in the following ways:

You can file a complaint:

- By calling South Carolina Solutions at 1-888-366-6243

- If you prefer to write, you may submit a complaint to:
South Carolina Solutions
Quality Management Department
1000 118TH Ave. North
St. Petersburg FL, 33716
- You can fill out the Complaint Form in the back of the Member Handbook (pages 9-10) and mail it in to the address listed on the form.

You may choose for your name to remain confidential or have your complaint shared with South Carolina Solutions and / or the provider. The Quality Management Department of South Carolina Solutions will investigate your complaint and follow procedures to resolve it as quickly as possible.

Grievances

If your Medicaid covered medical services:

- Have been reduced,
- Have been denied,
- Have been terminated,
- Have been suspended, or
- You have a problem that has not been taken care of properly

You have the right to file a grievance and request a hearing with the Division of Appeals. The grievance may be filed verbally or in writing. The request for a hearing must be put in writing and sent to:

Division of Appeals
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

The request for a hearing should explain what your problem is and why you want the hearing. If you need help to do this, call the South Carolina Solutions at 1-888-366-6243 for assistance.

We look forward to having you as a member of South Carolina Solutions Medical Homes Program.



MEMBERS' BILL OF RIGHTS

You have the right to receive information about the basic features of the **SOUTH CAROLINA SOLUTIONS** program before you join.

These are your rights as a member of **SOUTH CAROLINA SOLUTIONS**, including Care Coordination Services:

- ◆ To be treated with respect and dignity at all times
- ◆ To have your privacy protected.
- ◆ To take part in decisions about your health care, including your care plan.
- ◆ To refuse treatment or services, including care coordination services
- ◆ Restraint or seclusion will not be used as a way to force or punish you or for the convenience of any provider.
- ◆ To ask for and get a copy of your medical records.
- ◆ To ask that they be changed or corrected if you find a mistake.
- ◆ To receive health care services that are easy to get and do what they are supposed to do.
- ◆ To receive services that are right for you.
- ◆ To not be denied services just because of diagnosis, type of illness, or medical condition.
- ◆ To get information in a way that you can easily understand.
- ◆ To get help from both SCDHHS and your doctor in understanding your health plan.
- ◆ To get oral interpretation services free of charge if you don't speak English.
- ◆ To be told that oral interpretation is available and how to get those services.
- ◆ To get information on the program's services, to including, but not limited to:
 - ✓ Benefits and how to get them
 - ✓ Authorization requirements.
 - ✓ Any co-pays.
 - ✓ Service area.
 - ✓ Information on doctors that speak a language other than English.
 - ✓ Any limits on your freedom to choose a doctor.
 - ✓ Doctors not taking new patients.
 - ✓ Benefits not offered and how to get them
- ◆ To get information about Care Coordination services including:
 - ✓ How you would be selected for services
 - ✓ Case closure criteria
 - ✓ How to receive information about service changes or termination
 - ✓ Why services would be changed or terminated
 - ✓ What can you do if you are not able to participate
- ◆ To get a copy of your disenrollment rights at least once a year.
- ◆ To be told about any big changes in your Benefits.
- ◆ To get information on emergency and after-hours coverage, to include, but not limited to:
 - ✓ What emergency medical condition, emergency services, and post-stabilization services are.
 - That Emergency Services do not need prior authorization.
 - How to get Emergency services.
 - Where to go for emergency services.
 - Your right to use any hospital or other setting for emergency care.
 - Post-stabilization care services rules.
- ◆ To get the **SOUTH CAROLINA SOLUTIONS** policy on referrals for services not provided by your doctor
- ◆ To express your wishes regarding future treatment should you come incapacitated.
- ◆ To exercise these rights without fear of being treated differently.

SCS MEMBER and POTENTIAL MEMBER RESPONSIBILITIES

- ◆ To learn and understand each right you have under the South Carolina Solution (SCS) Medicaid Program. That includes:
- ◆ the responsibility to:
 - learn and understand your rights under the SCS Medicaid program;
 - ask questions if you don't understand your rights; and
 - learn what choices of health plans are available in your area.
- ◆ To abide by the SCS health plan and Medicaid policies and procedures. That includes the responsibility to:
 - learn and follow your health plan rules and Medicaid rules;
 - choose your health plan and a MHN PROVIDER quickly;
 - make any changes in your health plan and MHN PROVIDER in the ways established by Medicaid and by the SCS health plan;
 - always provide your Medicaid card to your MHN provider or any vendor providing care to you in order that your providers can bill Medicaid for your health care services
 - keep your scheduled appointments;
 - cancel appointments in advance when you can't keep them;
 - always contact your MHN PROVIDER first for your non-emergency medical needs;
 - be sure you have approval from your MHN PROVIDER before going to a specialist; and
 - understand when you should and shouldn't go to the emergency room (if you have questions please call your 24/7 nurse triage line (1-888-366-6243)).
- ◆ To share information relating to your health status with your MHN PROVIDER and become fully informed about service and treatment options. That includes the responsibility to:
 - tell your MHN PROVIDER about your health;
 - talk to your Providers about your health care needs and ask questions about the different ways your health care problems can be treated; and
 - help your Providers get your medical records.
- ◆ To actively participate in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
 - work as a team with your Provider in deciding what health care is best for you;
 - understand how the things you do can affect your health;
 - do the best you can to stay healthy; and
 - treat Providers and Staff with respect.
- ◆ To actively participate in SCS Case Management and/or Disease Education programs in order to stabilize and improve any chronic or complex conditions that you or a covered family member might have.
- ◆ If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr. You should also contact the South Carolina DHHS Managed Care Staff at 803-898-4614 if this is an issue.

COMMUNITY HEALTH SOLUTIONS OF AMERICA
NOTICE OF PRIVACY PRACTICES
Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

In the course of general business practice (treatment, payment, health care operations), Community Health Solutions of America, LLC, (CHS) and its contracted business associates may collect and/or exchange protected health information about an insured from and/or with persons other than the insured. This may include, but is not limited to:

- Medical records; and
- Previous health insurance coverage information including claims history, financial information, and demographics

This information is typically requested from or disclosed to:

- Physicians and other health care providers
- Hospitals
- Third party claims administrators;
- Insurance agents and brokers;
- Reinsurance carriers;
- Previous insurance carriers; and
- Employers

An insured's protected health information may be used, and disclosed to affiliated or non-affiliated third parties, by CHS without written consent or authorization from the insured for treatment, payment and health care operations as follows:

- Treatment – CHS may use or disclose protected health information in order for others to provide treatment to the insured. For example, CHS may disclose protected health information to an insured's health care provider in order to assist that provider in developing a specific plan of care. In addition, certain contracted physicians and business associates may contact an insured concerning appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the insured.
- Payment – CHS may use or disclose protected health information in order to obtain premiums or determine or fulfill its coverage and benefit responsibilities. For example, CHS may use, or disclose to third party claims administrators, protected health information to process and pay insurance claims. CHS may also disclose protected health information to providers or other insurance companies for their own payment-related activities, such as being paid for treatment that is not covered by CHS. In addition, CHS may disclose protected health information to the sponsor of the plan under which an insured is covered (for example, the insured's employer) if the sponsor certifies, among other things, that it will only use and disclose protected health information as permitted under the plan, will restrict access to protected health information to only those of its employees whose job it is to administer the plan, and will not use protected health information for any employment-related actions or decisions.
- Health Care Operations - CHS may use or disclose protected health information for its operations related to health care, and may disclose such information to others that have a relationship with a CHS insured (but only if such information pertains to such relationship). For example, CHS may use or disclose protected health information to conduct quality improvement activities or assist others in doing the same. Other payment and health care operation-related purposes for which CHS may use or disclose protected health information include the following:
 - Underwriting and enrollment;
 - Billing;
 - Claims processing;
 - Coordination of care;
 - Utilization review;
 - Quality assurance measurements, including surveys;
 - Accreditation;
 - Processing complaints, appeals and external appeals;
 - Reinsurance; and
 - Other operational needs as allowed by law and as required in the normal course of doing business

An insured's protected health information may also be disclosed to any state or federal agency (e.g. Medicaid and Centers for Medicare and Medicaid Services) under whose auspices benefits are being provided to the insured.

Unless an insured objects, CHS may provide relevant portions of the insured's protected health information to a family member or other relative, a friend, or any other person the insured indicates as being involved in the insured's health care or in helping the insured get payment for his or her health care. CHS may use or disclose protected health information to notify an insured's family or personal representative of the insured's location or condition. In an emergency or when an insured is not capable of agreeing or objecting to these disclosures, CHS will disclose protected health information as it determines is in the insured's best interest, but will tell the insured about it later, after the emergency, and give the insured the opportunity to object to future disclosures to family and friends. Unless an insured objects, CHS may also disclose protected health information to persons performing disaster relief activities.

An insured's protected health information may be used, and disclosed to affiliated or non-affiliated third parties, by CHS without written consent or authorization from the insured for the following other purposes permitted or required under the law:

- For Public Health Activities - For example, CHS discloses protected health information when it reports the occurrence of certain diseases and vital events such as a birth or death.
- For Reports About Victims of Abuse, Neglect or Domestic Violence - CHS will disclose protected health information in these reports only if it is required or authorized by law to do so, or if the insured otherwise agrees.
- To Health Oversight Agencies - CHS will provide protected health information as requested to government agencies that have authority to audit or investigate its operations.
- For Lawsuits and Disputes - If an insured is involved in a lawsuit or dispute, CHS may disclose protected health information in response to a subpoena or other lawful request, but only if efforts have been made to tell the insured about the request or to obtain a court order that will protect the protected health information requested.
- To Law Enforcement - CHS may release protected health information if asked to do so by a law enforcement official, in the following circumstances: (a) in response to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect, fugitive, material witness or missing person; (c) about the victim of a crime if, under certain limited circumstances, CHS is unable to obtain the person's agreement; (d) about a death CHS believes may be due to criminal conduct; (e) about criminal conduct at a CHS facility; and (f) in emergency circumstances, to report a crime, its location or victims, or the identity, description or location of the person who committed the crime.
- To Coroners, Medical Examiners and Funeral Directors - CHS may disclose protected health information to facilitate the duties of these individuals.
- To Organ Procurement Organizations - CHS may disclose protected health information to facilitate organ donation and transplantation.
- For Medical Research - CHS may disclose protected health information to medical researchers who request it for approved medical research projects; however, with very limited exceptions such disclosures must be cleared through a special approval process before any protected health information is disclosed to the researchers, who will be required to safeguard the protected health information they receive.
- To Avert a Perceived Serious Threat to Health or Safety - CHS may disclose protected health information to someone who can help prevent a perceived serious threat to the health or safety of a person or the public.
- For Specialized Government Functions - For example, CHS may disclose protected health information to authorized federal officials for intelligence and national security activities that are authorized by law, or so that they may provide protective services to the President or foreign heads of state or conduct special investigations authorized by law.
- To Workers' Compensation or Similar Programs - CHS may provide protected health information to these programs in order for an insured to obtain benefits for work-related injuries or illness.
- When Required by Law - CHS will disclose protected health information whenever it is required to do so by federal, state, or local law. State and federal law may impose more restrictive requirements than those listed above on certain uses and disclosures of protected health information by CHS and its business associates. CHS and its business associates will comply with all such applicable requirements.

II. CHS'S OBLIGATIONS AND OTHER RIGHTS

CHS and its contracted business associates must:

- Maintain the privacy of an insured's protected health information and provide the insured with notice of its legal duties and privacy practices with respect to the insured's protected health information; and
- Abide by the terms of the notice currently in effect.

CHS reserves the right to change the terms of the notice and make the new notice provisions effective for all protected health information that it maintains. A revised notice will be provided to an insured through any of the following methods: Mailing, Internet, newsletter, or any other method as allowed by law.

If an insured's protected health information is to be used or released for any purpose other than in the conduct of normal business practices, a special written and signed authorization from the insured or their legal guardian or designee will be obtained prior to releasing such information. This authorization may be revoked at any time by the insured or his or her designee. However, the revocation will not affect any use or disclosure made before the date the authorization is revoked, or to the extent to which it has been relied upon by the recipient of the protected health information. Any information collected by a contracted business associate may be retained by it and disclosed to other persons as permitted by law.

III. INSURED RIGHTS

An insured has the right:

- **Restrictions** - To request restrictions on the use and disclosure of protected health information by CHS and its contracted business associates (a) for only those purposes described in Section I of this Notice and (b) to the Secretary of the Department of Health and Human Services. Neither CHS nor those contracted business associates acting on CHS's behalf are required to agree to a requested restriction. Any such request must be submitted in writing to the CHS Customer Service Representative identified at the end of this section. If CHS agrees to an insured's request, the agreement will be put in writing, and CHS will abide by the agreement except in the case of emergency treatment;
- **Confidential Communications** - To request and to receive communications of protected health information by alternative means or at alternative locations if disclosure could endanger the insured. Any such request must be submitted in writing to the CHS Customer Service Representative identified at the end of this section;
- **Inspect and Copy** - To inspect and copy documents containing protected health information, except in limited circumstances. Any such request must be submitted in writing to the CHS Customer Service Representative identified at the end of this section. CHS will respond to any such request within 30 days (60 days for records not maintained on site). Any denial by CHS to such a request will be in writing and will explain the insured's rights regarding such denial;
- **Access and Amendment** - To access protected health information retained by CHS and correct this information where inaccurate. Any such request must be submitted in writing to the CHS Customer Service Representative identified at the end of this section and must include an explanation of why the insured thinks an amendment is appropriate. CHS will respond to any such request within 60 days (90 days if extra time is needed). Any denial by CHS to such a request will be in writing and will explain the insured's rights regarding such denial;
- **Accounting** - To receive a free accounting of disclosures of protected health information that CHS has made during the prior 6 years, or shorter time if requested (excluding certain disclosures, including disclosures made for treatment, payment and health care operations activities). Any such request must be submitted in writing to the CHS Customer Service Representative identified at the end of this section. CHS will respond to any such request within 60 days (90 days if extra time is needed). The insured will be charged the cost of providing any additional accountings requested within a 12 month period; and
- **Paper Copy** - To receive a paper copy of this notice upon request. Any such request must be submitted in writing to the CHS HIPAA Privacy Official identified at the end of this section. This notice is also available on CHS's web site at <http://www.sc-solutions.org/>.

Complaints:

- If an insured feels that his or her privacy rights have been violated, he or she may submit a complaint to CHS or the Secretary of the Department of Health and Human Services.
- To file a complaint with CHS, simply submit a written complaint to the CHS Customer Service Representative identified at the end of this section.
- Insureds will not be retaliated against for filing a complaint.

Requests (and all supporting information, as described above) and complaints should be sent to the following CHS Member Service Representative:

**CHS HIPAA Privacy Official
1004 118th Avenue North
St. Petersburg, FL 33716
1-888-366-6243**

If an insured needs any further information concerning this notice or its statements, the insured should contact CHS's Privacy Official at 1-888-366-6243.

Community Health Solutions of Louisiana (CHS-LA)
CCN-S Proposal Submission
Geographic Service Area: A, B, C

Section K: **Member Materials (Section 11 of RFP)**

Requirement K.1: *Describe proposed content for your member educational materials) and attach examples used with Medicaid or CHIP populations in other states.*

Attachment 2: Sample South Carolina Solutions Brochure

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To get questions answered call
1-888-6 GET SCS
 (1-888-643-8727)

To enroll call
 Healthy Connections Choices
 Monday thru Friday / 8:00 a.m. to 6:00 p.m.
 1-877-552-4642
 TTY: 1-877-552-4670



Para obtener este folleto en español,
 llame al 1-877-552-4642

*All calls are free and private
 Free interpreter services are available*

You can also enroll online at
www.SCchoices.com

This is a voluntary program but is subject to change pending CMS approval.

Solutions for a Healthier Life!



For more information on why you should enroll in *South Carolina Solutions* visit us online at www.sc-solutions.org or  on Facebook by searching for *South Carolina Solutions*.

Call Toll Free
1-888-6 GET SCS
 (1-888-643-8727)



A Medical Homes Network Program



Why Choose South Carolina Solutions for Your Medicaid Health Plan?

You Choose Your Doctor!
Unlimited Doctor Visits!
No Co-Pays!

What is South Carolina Solutions?

South Carolina Solutions is not like other health plans. As South Carolina's largest Medical Homes Network, you are free to choose from over 1,600 South Carolina Solutions primary care doctors that you would like as your Medical Home. Then that Medical Home will assist you in getting the health care you need including specialty, inpatient and outpatient care, as well as help you with your prescriptions.

Why Choose a Medical Home?

Having a **Medical Home** means your doctor will get to know you and your family. You will have a doctor to treat you when you are ill and your doctor will provide check-ups and health evaluations.

Having a doctor who knows you, your family, and your medical history allows the doctor to make the best choices and recommendations about your health care.



What Extra Benefits Are Offered?

You keep all your fee-for-service Medicaid benefits, including pharmacy and transportation to medical appointments, plus you get:

- ◆ Unlimited Doctor Visits!
- ◆ No Co-Pays!
- ◆ Anytime day or night you have telephone access to a Nurse
- ◆ Your choice of any South Carolina Solutions primary care doctor as your Medical Home
- ◆ Access to all specialists, hospitals, and pharmacies enrolled in the Medicaid program
- ◆ Text4baby - Free text messages each week on your cell phone to help you through your pregnancy
- ◆ Help managing your chronic illnesses



Do You Have a Chronic Illness?

South Carolina Solutions specializes in treatment of children and adults with chronic illnesses. You will have someone help you manage your chronic illness better. Your doctor is free to refer you to a provider or specialist enrolled in the Medicaid program.

Care Management and Disease Education are available to help you manage your chronic disease. For more information on all that South Carolina Solutions has to offer call 1-888-643-8727 or visit www.sc-solutions.org.

1-888-6 GET SCS
 (1-888-643-8727)

Enroll Today!
It's Fast and Easy!



Call Healthy Connections Choices and tell them you want to enroll in the *South Carolina Solutions* health plan.

Solutions for a Healthier Life!

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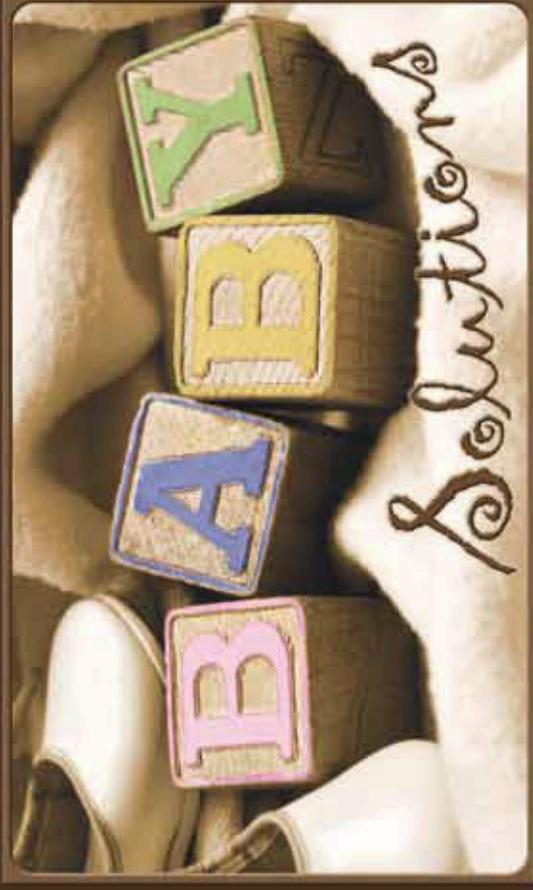
Community Health Solutions of Louisiana (CHS-LA)
CCN-S Proposal Submission
Geographic Service Area: A, B, C

Section K: **Member Materials (Section 11 of RFP)**

Requirement K.1: *Describe proposed content for your member educational materials) and attach examples used with Medicaid or CHIP populations in other states.*

Attachment 3: Sample “Before I Was Born” Maternity Calendar pages

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BEFORE I WAS BORN

from Conception to Birth

Month Five

Baby's Progress

Your baby can now suck his thumb. You may start feeling movement. Baby now has sleep and wake cycles. The baby is 10 inches long and weighs ½ to one pound.

Expectations

Exercise:

Regular exercise during pregnancy will keep you fit and feel more comfortable. The benefits of at least 30 minutes of exercise most days may include:

- Reduced backaches, constipation, bloating, and swelling
- Prevention or treatment of gestational diabetes
- Increased energy levels
- Improved mood and sleep
- Better muscle tone, strength, and endurance.
- Easier and shorter labor

There is no reason to stop exercising while pregnant. Just follow these simple rules and ask your doctor if you are unsure:

Did You Know...



Shortness of breath is common during pregnancy. Try propping up with pillows.



The CDC reports secondary smoke may cause low birth weight babies.



Sometimes you may have normal vision changes. Usually blurred, dry, irritated. Contacts may not be comfortable. Always mention these changes to your doctor, as some changes are a sign of gestational diabetes or high blood pressure.

- Increase fluid intake.
- Listen to your body and stop when you are fatigued.
- Avoid activities that involve high impact, jumping, or any chance of falling or being struck.

Some of the best activities when pregnant include:

- Swimming
- Riding stationary bike
- Walking
- Low impact aerobics

Do not lie on your back to exercise after first trimester.

Reminder:

Don't forget to sign up for childbirth classes.

Aspirin, acetaminophen, ibuprofen, and cold medicines should not be taken in pregnancy without first consulting your doctor.



Month _____ Prenatal Appointment Dates Questions to Ask Your Doctor

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—

Month Eight

Baby's Progress

Most development is finished. The baby starts to gain weight more quickly. The baby may now hiccup and can taste. The baby is up to 18 inches long and weighs up to 5 pounds.

Expectations

Getting Ready:

As your due date gets closer, you are probably seeing your doctor for prenatal appointments every week. The doctor may perform a vaginal exam to check for changes in your cervix. The changes that will occur are effacement and dilation. Effacement is the gradual softening and thinning of the cervix. Dilation is the gradual opening of the cervix and is measured in centimeters. Ten centimeters is considered complete and wide enough for the baby to be born. Your body will give several signals to let you know your due date is near:

- Weight - your weight will level out or decrease.

Did You Know...



During the last few weeks of pregnancy lightening will occur. This is when your baby drops into your pelvis. If this is your first pregnancy, lightening usually happens about two weeks before delivery.



Swollen feet and ankles can be caused by the weight of your uterus slowing down the flow of blood back from your legs. To help ease the pain of aching legs and feet try one of the following:

- Take plenty of walks.
- Avoid standing for long periods of time.
- Wear support stockings.
- Elevate your feet when possible.
- Drink plenty of water.



Stretch marks may appear on your breasts, stomach, and thighs. The marks are dark purple in color but will fade in color after the baby is born. You cannot prevent stretch marks, but applying oils and moisturizing lotion may help ease the itching.

- False labor contractions - these will become more frequent and intense.

- Lightening - the baby's head will drop into the pelvic area, causing increased pressure and discomfort in your lower back.

- Loss of mucous plug - when the cervix loosens, the mucous plug will be discharged. This normally means labor will begin within a few days.

Reminder:

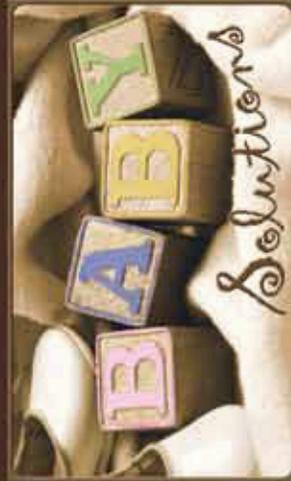
- Now is the time to research and choose a health plan and pediatrician for your baby. Your baby will be eligible for Medicaid for 12 months after birth. This choice should be made within the first 30 days of life.

- It is important that you continue to take your prenatal vitamins every day.

- You may feel uncomfortable wearing a seat belt. You should adjust the lap belt so that it fits comfortably and securely under your abdomen. Wear the shoulder belt as well.

Month _____ Prenatal Appointment Dates _____ Questions to Ask Your Doctor _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—



a Maternity Education Program
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Section K: **Member Materials (Section 11 of RFP)**

Requirement K.1: *Describe proposed content for your member educational materials) and attach examples used with Medicaid or CHIP populations in other states.*

Attachment 4: Sample “Understanding Asthma” pages

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Understanding ASTHMA



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SESSION 3

RISK FACTORS OR TRIGGERS

There are 2 things that put you at risk for having asthma. They are called **inherent risk factors** and **external risk factors**. **External risk factors** are those things that you may come in contact with that cause asthma symptoms.

INHERENT RISK FACTORS

Inherent risk factors are things that either you or your family have that put you at greater risk:

1. Gender – boys are at greater risk than girls as children to have asthma
2. Family history – If your father or mother has asthma then you are at a greater risk
3. Allergies – if you have allergies you are more likely to have asthma.

EXTERNAL RISK FACTORS

The external factors are the things that you need to do something about. They are things that are in your home, in the air, at your job, and in your school room. They are also activities that you do, habits that you have, and things in the food you eat that can cause asthma symptoms.

External triggers or risk factors include:

1. Tobacco smoke
2. Allergens like pets, cockroaches, outdoor pollens, dust mites, and molds
3. Air pollution – smog, wood smoke, and exhaust
4. Irritants at Work – chemicals, fumes, dust, metal, latex
5. Irritants at Home – aerosol sprays, cleaning supplies
6. Physical Activity – sports, aerobic exercise, distance running
7. Drugs and food additives – sulfites, beta blockers, aspirin, NSAIDs (Advil or Motrin)
8. Cold or dry air

9. Stress or intense emotion – anxiety, worry, difficult family or work situations
10. Pet dander

Once you know your triggers, you should protect yourself from them.

- Change things in your home like carpets. Place covers on your furniture and mattress.
- Change habits like smoking.
- Stay inside when air is polluted.
- Wear a mask at work.



Most Important Factor!

If there is only one thing, besides taking your medicine, that you can do to help control your asthma it is staying away from tobacco smoke!

www.scdhec.gov/quitforkeeps

PREVENTION

There is no way to fully prevent asthma or cure it. There are ways to help prevent you from having an asthma attack:

1. Avoid your asthma triggers
2. Learn about your asthma
3. Measure your peak flow twice daily
4. Take your medicine as your doctor ordered
5. Follow your zone management plan
6. Keep your appointments with your doctor



Attention!

Even if you smoke outside, smoke gets on your clothes and can be a risk factor for your child!

SESSION 4

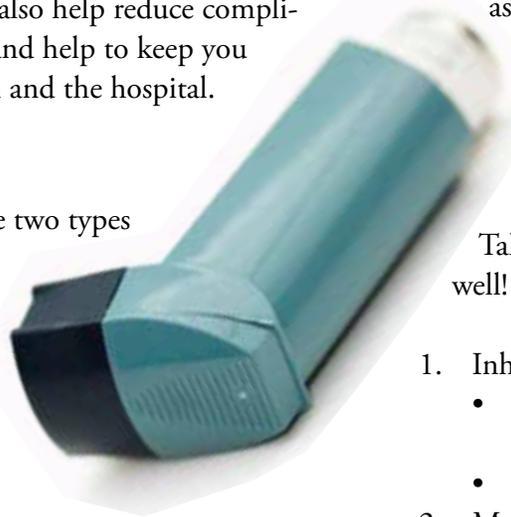
MEDICATION MANAGEMENT

Your doctor will give you medicine(s) to help you manage your asthma. These medicines directly treat your lungs by controlling the bronchial spasm and irritation in your lungs. They will control your symptoms and will help you be able to do your routine daily activities. These medicines also help reduce complications from your asthma and help to keep you out of the emergency room and the hospital.

ASTHMA MEDICATIONS

Your doctor will usually use two types of medicine to treat your asthma:

1. **Quick relief or rescue medicine**
2. **Long term control medicine**



Both your doctor and your care coordinator will spend time telling you about each of your medicines, what they are being used for, and any possible side effects. It is important that if you have any of these side effects that you call your doctor immediately. Your doctor will then decide if you should continue or change your medicine or change the dosage.

QUICK-RELIEF RESCUE MEDICATIONS

Medicines for quick relief include rescue inhalers and oral steroids. These medicines are taken to relieve symptoms quickly during asthma episodes.

1. **Short Acting Inhaled Beta2-agonists**
 - Rescue medicine
 - Bronchodilator (opens tubes)
 - Reverses spasm of the tubes
2. **Oral steroids**
 - Used only short term
 - Used to stop or decrease acute asthma and prevents flare ups
 - Can be used long term for severe persistent asthma class

Peak flows help to guide when to use quick relief medicines.

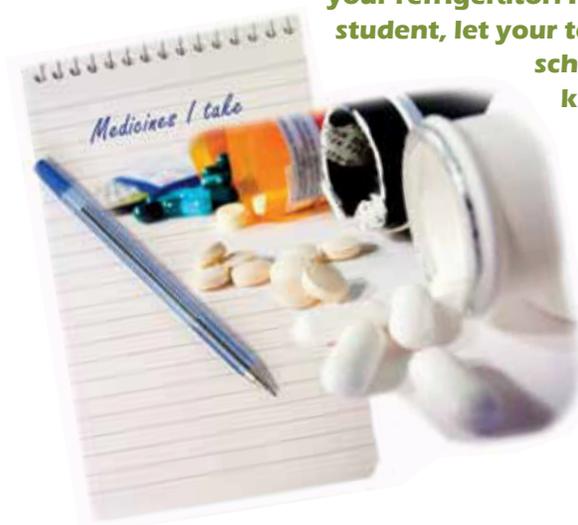
LONG-TERM CONTROL MEDICATIONS

These medicines are used every day to help prevent asthma symptoms. Each group has certain symptoms or disease problems that it is used to control. These medicines need to be taken daily to control spasms of the tubes. They can prevent repeated asthma problems.

Take your medicine every day, even if you feel well!

1. Inhaled Steroids
 - Most effective drug to decrease irritation and swelling in the tubes and lungs
 - Reduces asthma symptoms
2. Mast Cell Stabilizers
 - Decreases irritation of the tubes
 - Used to prevent EIA (exercise induced asthma)
3. Leukotriene Modifiers
 - Taken by mouth to block inflammation
4. Long-Acting beta2-agonists
 - Open up the airways
 - Used to maintain control of asthma symptoms

Always keep a list of your medicines with you. Also, always leave a copy of your medicines on your refrigerator. If you are a student, let your teacher or the school nurse know that you have asthma and what medicines you take.



SESSION 6

ASTHMA ZONE MANAGEMENT PLAN

It is important that your doctor gives you a zone management plan to help you take care of your asthma every day no matter what your symptoms may be. Your doctor will ask you to use this to quickly take care of any symptoms you have. Your doctor will also tell you when they want you to call them if the treatment that you are to use does not make your symptoms better. Your doctor will set up your plan like a traffic light; the colors will go with the type of symptoms you are having. The three zones are **GREEN**, **YELLOW** and **RED**. Each zone will have certain things that you should do or medicine doses that you should take or use. You will use your Peak Flow Meter to tell you what zone you are in and how strong your symptoms are or how often you have them. You and your doctor will decide what your best Peak Flow Meter reading is so that you will know what zone you fall in based on your Peak Flow reading. You will take this reading in the morning or when your symptoms change.



GREEN ZONE:

1. **Green means all systems are “GO.”** Your asthma is under control.
2. **Peak flow reading:** 80-100% of your normal reading
3. **Symptoms:** No asthma symptoms
4. **Actions:** Take your long term medicine

YELLOW ZONE:

1. **Yellow means “CAUTION.”** You are having mild asthma symptoms.
2. **Peak flow reading:**
 - **HIGH YELLOW** is 65-79% of your normal reading
 - **LOW YELLOW** is 50-65% of your normal reading

3. **Symptoms:**
 - Shortness of breath
 - Coughing, tight cough
 - Tired, low energy
 - Fast breathing
 - Trouble breathing out
4. **Actions:**
 - Use your rescue medicine
 - If you are in the **HIGH YELLOW** zone you should go back to the **GREEN ZONE** in 3 days. If not call your doctor.
 - If you are in the **LOW YELLOW** zone and don't get better in 2-6 hours start your **RED ZONE** treatment plan. If you don't get better, call your doctor.

REMEMBER: Peak flow meters are the key to guiding therapy!

RED ZONE: DANGER ZONE!

1. **Red means “STOP!”** Get medical attention immediately. This is your emergency zone.
2. **Peak flow reading:** Below 50% of your normal reading
3. **Symptoms:**
 - Severe shortness of breath, can't get a breath
 - Your nostrils flare
 - You hunch your body to get a breath
 - You can't walk more than a few feet
4. **Actions:**
 - Use your rescue medicine and your rescue inhaler
 - Have someone call the doctor NOW
 - If you don't get better in a few minutes go to the Emergency Room
5. **Call 911 if you have these symptoms:**
 - Gaspings for air
 - Lips turn blue or gray
 - Extreme anxiety due to difficulty breathing
 - Condition is getting worse after you have used rescue medicine

Keep a copy of this plan with you.

SESSION 7

NUTRITION

A good diet is important for people with chronic diseases. If you're not getting the right nutrients, you may be more likely to get sick and it may be harder for you to fight infections that can trigger an asthma attack.

Just like regular exercise, a healthy diet is good for everyone. Being overweight is associated with more severe asthma.

People who have asthma and are overweight are likely to need more medicine and miss more work or school than people of a normal weight.



Some medicine can put you at risk for other diseases such as osteoporosis. This is a disease where your bones become weak because they have lost calcium. Talk to your doctor about this risk.

GOOD NUTRITION

1. Eat plenty of fruits and vegetables.
2. Eat foods with omega-3 fatty acids, like salmon, tuna, sardines and some plant sources, like flaxseed.
3. Avoid trans fats and omega-6 fatty acids, like those found in some margarines and processed foods.
4. Watch your calories, because if you eat more calories than you burn, you will gain weight.
5. Know your food allergies, talk to your doctor about how any food allergies you might have could affect your asthma.
6. You can drink milk! Stopping all dairy from your diet will not necessarily improve your asthma control. It's simply "an old wives tale."
7. Preservative sensitivities, for some people, sulfites can trigger temporary symptoms. Sulfites can be found in some processed foods, condiments, dried fruits, canned vegetables, wine, and other foods.

8. AVOID high fat meals, they can increase inflammation and trigger asthma attack.

STAY HYDRATED

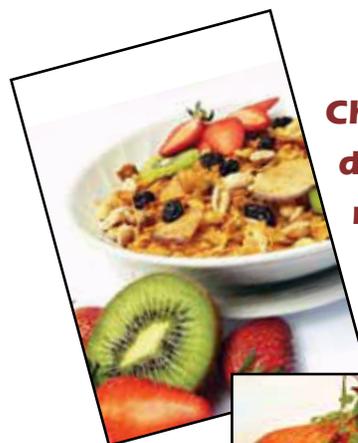
It is important to drink plenty of water if you have asthma. Any time your lungs get dry you have a greater chance for an asthma attack.

1. Dehydration can cause bronchial irritability
2. Water helps to thin mucus and make breathing easier
3. Moist air helps keep you from having bronchospasm

GASTROESOPHAGEAL REFLUX DISORDER (GERD)

Up to 70% of all people with asthma also have GERD (reflux of stomach acid), which can make asthma more difficult to control.

1. Sometimes GERD doesn't cause heartburn symptoms.
2. Weight loss is often all that is necessary to eliminate GERD.
3. Try eating smaller meals and cutting down on alcohol and caffeine.
4. Avoid eating 4 hours before bedtime.
5. If you have GERD, you may need to take medicine. Ask your doctor.



Check with your doctor about the right food and exercise for you.



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Section K: **Member Materials (Section 11 of RFP)**

Requirement K.1: *Describe proposed content for your member educational materials) and attach examples used with Medicaid or CHIP populations in other states.*

Attachment 5: Sample “Understanding Sickle Cell” pages

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Understanding Sickle Cell Disease



MEDICAL WORDS TO KNOW

Anemia – a condition where there aren't enough red blood cells to carry oxygen through the body

Antibiotic – a medication produced to inhibit or kill an infection

Bone Marrow – the red, spongy material found within the cavities of many of the large bones which makes red blood cells

Gene – you get these from your parents, and they determine things such as hair texture, color of skin, shape of nose, including the kind of hemoglobin in the red blood cells

Genetic counseling – communication between a health care provider and a client who gets accurate and up to date information about a genetic disorder in a sensitive and supportive way

Hemoglobin – the red, iron rich protein that gives blood its red color; it's in every red blood cell in the body; it allows red blood cells to carry oxygen from the lungs to all parts of the body and carbon dioxide waste from other parts of the body to the lungs so it can be exhaled

Hematologist – a doctor who is an expert in diseases of the blood

Infection – a disease caused by germs in the body, including bacteria, viruses or parasites

Inherit – to get a trait from a parent through passing along of a gene

Jaundice – yellow discoloration of the skin and eyes

Liver – the large organ that plays a major role in metabolism, digestion, detoxification and elimination of substances from the body

Oxygen – a chemical element in the air we breathe; needed to sustain life

Penicillin – an antibiotic used to prevent infection with or kill certain types of bacteria

Red Blood Cell – the cells in the blood which contains hemoglobin

Retina – the innermost layer of the eyeball

Sickle Cell Anemia – an inherited disorder where the child gets two sickle cell genes, one from each parent

Sickle Cell Trait – inheritance of one gene for sickle cell and one normal gene

Spleen – this organ forms and stores blood, if injured or removed, may lead to greater risk of infection

Symptom – signs of a disease felt by the patient

Transfusion – injection of blood or blood products through a vein into the body

Transplant – the transfer of organs or tissue from a donor to another person.

SESSION 1

WHAT IS SICKLE CELL DISEASE?

SICKLE CELL DISEASE

- Both Mom and Dad pass the gene to their child
- The body make a different kind of hemoglobin – hemoglobin S – where the “S” stands for sickle
- Can lead to serious health issues

SICKLE CELL TRAIT

- Have 1 normal and 1 sickle cell gene
- Bodies make both normal hemoglobin and sickle cell hemoglobin
- Usually have no signs or symptoms, but can in certain situations
- Can pass the gene to their children

WHERE DOES IT COME FROM?

- Caused by a mistake in the gene that makes hemoglobin
- Parents pass the gene to children
- Sickle Cell Disease refers to 5 conditions, including: Sickle Cell Disease and Sickle Cell Trait
- Red blood cells with healthy hemoglobin are round and smooth
- Red blood cells with unhealthy hemoglobin are hard, sticky, and moon shaped
- Sickle cell disease cannot be “caught” from another person

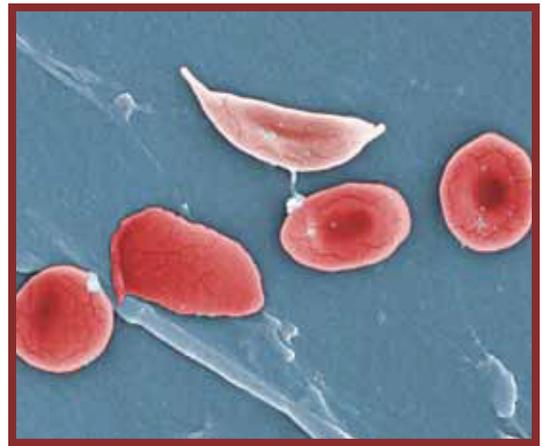
NORMAL BLOOD CELLS

- Flexible and round
- Move easily through the blood, carrying oxygen through the body

SICKLE CELLS

- Become stiff and sticky
- Change shape into moon shape – or sickles

- Die before normal cells do, so there are not enough in the blood
- Get stuck when flowing through small blood vessels
- When stuck, this keeps oxygen and blood from parts of the body
- This causes the pain and problems associated with the disease



Healthy and Unhealthy Blood Cells

NOTES

SESSION 4

COMPLICATIONS OF SICKLE CELL ANEMIA

STROKE

- Can occur if sickle cells block blood flow to the brain
- Signs include seizures, weakness or numbness in arms and legs, speech difficulties and loss of consciousness

ACUTE CHEST SYNDROME

- Caused by lung infection or sickle cells blocking blood vessels in the lungs
- Signs include chest pain, fever, and difficulty breathing

SPLENIC CRISIS

- The spleen traps cells that should be in the blood stream, causing the spleen to grow large
- If the spleen gets too clogged with sickle cells it won't work right. This can cause the spleen to shrink
- May need blood transfusions until the body can make more cells and recover

ULCERS ON LEGS

- Sickle cells block blood vessels that feed skin, causing skin cells to die
- Sores develop on damaged skin

GALLSTONES

- When red blood cells break down, they release chemicals such as bilirubin that can lead to gall stones

BLINDNESS

- Sickle cells can block the small blood vessels in the eyes
- This can damage the retina and lead to blindness

PRIAPISM

- Men may have painful and unwanted erections when cells block blood flow out of an erect penis

ORGAN DAMAGE

- Sickle cells block blood flow, hurting organs

NOTES

SESSION 5

DIAGNOSTIC TESTS

TESTS AND DIAGNOSIS

- A blood test can check for hemoglobin S – the hospital will do this test for all new babies, but older children and adults can be tested too
- A blood sample is drawn from a vein in the arm, or for babies from a finger or heel
- The sample is sent to a lab for testing
- If the test is negative, then there is no sickle cell gene
- If it is positive, more tests will be done to see if the patient has sickle cell trait or anemia
- Another blood test is for anemia – to see if there is a shortage of red blood cells
- People with sickle cell often see a doctor who is an expert on blood-related diseases (a hematologist)



- The urine should be tested regularly
- Eyes should be tested regularly starting at age 10
- Children starting at age 2 may have an ultrasound of the head to look at the blood flow to the brain

SPECIAL TESTS

- For bad headaches: MRI, transcranial doppler ultrasound, or MRA
- For stomach pain: abdominal ultrasound
- For pain in hip or joint: x-ray or MRI

REGULAR TESTS

- First time values for hemoglobin, hematocrit, reticulocyte count, white blood cell count and liver and renal function
- These should be checked on a regular basis
- The doctor should give you a copy of the labs to share with the ER when needed
- Iron levels should be measured in people getting transfusions

NOTES

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Section K: **Member Materials (Section 11 of RFP)**

Requirement K.2: *Describe how you will ensure that all written materials meet the language requirements and which reference material you anticipate you will use to meet the sixth (6th) grade reading level requirement.*

Response: Community Health Solutions of Louisiana (CHS-LA) will ensure that all written materials meet, or exceed, the language requirements through the use of Microsoft Word’s Readability function. CHS-LA will use this function to determine the Flesch-Kincaid grade level rating of written materials and to amend those materials, as necessary, to meet the Flesch-Kincaid sixth (6th) grade level requirement of the State.

CHS-LA believes it is important for Members to develop the skills to engage actively in their own health care. Therefore, we promote medical literacy and do include accurate medical terms in our written materials. These terms often do not meet grade level. We address this by providing our Members with a glossary of medical terms and definitions; the definitions do meet grade level requirements.

Currently, all materials for our South Carolina Medicaid Members are written at the fourth (4th) grade reading level. That level is demonstrated in the attachments associated with CHS-LA’s response to K.1. CHS-LA will strive to exceed Louisiana’s requirement of sixth (6th) grade level and will develop materials, whenever possible, at a fourth (4th) grade level.

CHS-LA will utilize internal proofreaders to ensure compliance with DHH’s Person First Policy, as required in Section 11.10.1 and articulated in Appendix EE.

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Section K: **MEMBER Materials (Section 11 of RFP)**

Requirement K.3: *Describe your process for producing Member ID cards and information that will accompany the card. Include a layout of the card front and back. Explain how you will ensure that a Member receives a new Member ID card whenever there has been a change in any of the information appearing on the Member ID card.*

Response: Community Health Solutions of Louisiana (CHS-LA) will issue a black and white, plastic Member ID card to every Member containing, at a minimum, the following information:

- Member’s name and date of birth
- CHS-LA’s name and address
- Instructions for emergencies
- PCP’s name and telephone number(s) (including after-hours number, if different from business hours number)
- Toll-free numbers for
 - 24-hour Member Services and Filing Grievances
 - Provider Services and Prior Authorization
 - Reporting Medicaid Fraud

If the Member has not selected a PCP at time of issuance and mailing of their Member ID card, the card will be issued without the PCP information. Upon receipt of Member PCP information, a new Member ID card will be issued and mailed to the Member.

The Member ID card will be issued and delivered to the Members with their Member Welcome Packet. Included with the Member’s ID card will be an explanation of:

- Purpose of the card
- How to use the card
- How to use the card in tandem with the DHH-issued card

The process for producing Member ID cards begins with receipt of the eligibility file from the enrollment broker which is imported into our Eligibility/Claims Data system (ECD). Our ECD system reviews the

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data to identify:

- New Members
- Change in Member's name
- Change in Member's PCP
- Corrections to previously received information

Within the ECD system, an internal flag will be placed on all Members' files meeting one or more of the above bullets and a record will be written to the system database. In addition, if a Member contacts our Member Services department because they have lost their Member ID Card or to report that their Member ID Card was stolen, our Member Services staff members have the ability to flag the Member's file for a replacement card. All Member ID cards are reissued within ten (10) calendar days of request notification. CHS-LA's ECD system tracks the date Member ID cards are issued and the reason for issuance such as New Member, change in information, or loss of card.

On a daily basis, an automated Extract, Transform, Load (ETL) process is completed by the system and the data for Members requiring an ID card is dynamically transferred to our internal fulfillment center. ETL processes in the fulfillment center continually monitor the network. Once a file is detected, it is loaded by the system and an electronic notification is sent to CHS-LA's fulfillment team. The fulfillment team will then proceed with production and mailing of the new Member ID Cards and Welcome Packets and any replacement ID cards. In the case of new Members, Member ID cards are issued within ten (10) calendar days of receipt of notification from DHH.

If CHS-LA identifies that the holder of the Member ID card is not the Member or their guardian, or if we obtain knowledge of any CHS-LA Member permitting the use of this ID card by any other person, we shall immediately report this violation to the Medicaid Fraud Hotline.

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CHS-LA ID Card: Front



Member Name: John Doe
Member State ID: 12345
Member DOB: 00/00/0000

Co-pay: \$00
Effective: 00/00/0000

Physician: William Doe, M.D.
000-000-0000
(000-000-0000 after hours)



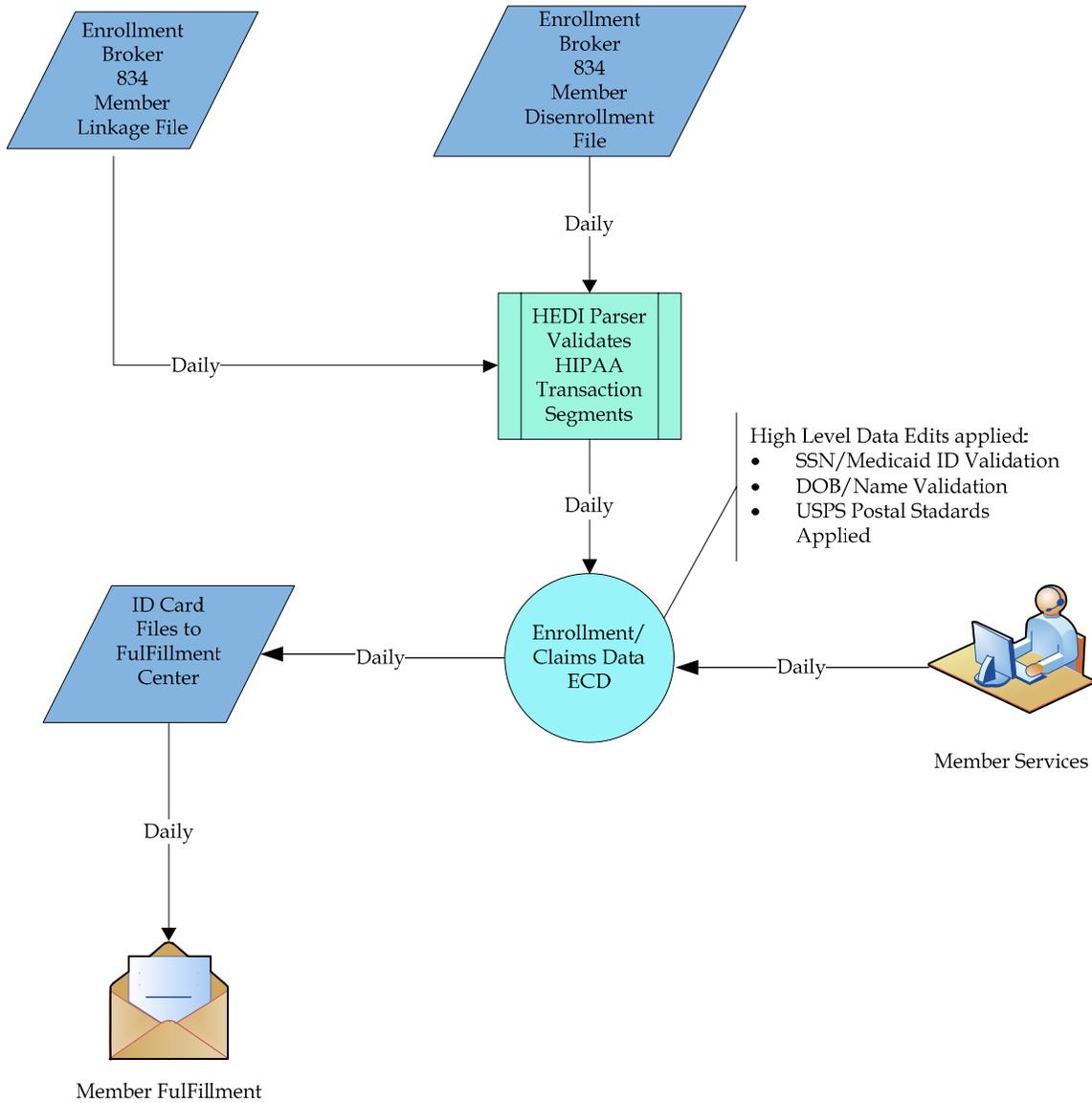
CHS-LA ID Card: Back

Community Health Solutions of Louisiana
P.O. Box 66518
Baton Rouge, LA 70896

1-800-000-0000 24-hour Member Services or to file a grievance
1-800-000-0000 Provider Services and Prior Authorization
1-800-488-2917 To Report Medicaid Fraud

In Case of Emergency:
If life threatening Call 911
If non-life threatening call 24 hour nurse line at 1-800-000-0000

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Section K: **Member Materials (Section 11 of RFP)**

Requirement K.4: *Describe your strategy for ensuring the information in your provider directory is accurate and up to date, including the types and frequency of monitoring activities and how often the directory is updated.*

Response: Community Health Solutions of Louisiana (CHS-LA) will use the following strategies to ensure that our Provider Directory is accurate and up to date:

- CHS-LA maintains provider information in a centralized internal database that is updated on a real-time basis through automatic updates initiated by our Credentialing Department.
 - New information is added, on a real-time basis, as new contracts are received.
 - Updates are made, on a real-time basis, as the Credentialing Department is notified of changes by our Provider Services and Provider Call Center staff.
- While CHS-LA strives to update provider information on a real-time basis, we have built weekly, monthly, and quarterly opportunities for updates into our monitoring system to ensure that we are reflecting, in our Provider Directory, current and accurate provider information. If, during any of these opportunities, a change or inaccuracy is noted, an updated application is completed and processed through our credentialing system which automatically updates our centralized internal database.
 - Provider Services and Provider Call Center staff are provided with the most current version of the Provider Directory on a weekly basis. They are asked to notify the Credentialing Department of any inaccuracies among the providers for whom they are the designated point of contact.
 - Provider Call Center staff carry out monthly telephonic monitoring calls with each of their provider’s practice administrator/office manager for verification of the following:
 - physicians associated with practice (record any additions or deletions)
 - capacity
 - contact person
 - email address

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- enrollment option
- mailing address
- ownership
- payment address/W-9
- Provider Services Representatives meet on-site with providers for whom they are the designated point of contact within ten (10) business days of contracting for the initial provider training and then on a quarterly basis. During these on-site visits they verify all provider data identified above.

CHS-LA updates the Provider Directory on our website on a monthly basis. Our website includes a searchable web interface for our Members as well as a complete Provider Directory, which is posted in Adobe PDF format.

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Section K: **Member Materials (Section 11 of RFP)**

Requirement K.5: *Describe how you will fulfill Internet presence and Web site requirements, including:*

- *Your procedures for up-dating information on the Web site;*
- *Your procedures for monitoring e-mail inquiries and providing accurate and timely responses; and*
- *The procedures, tools and reports you will use to track all interactions and transactions conducted via the Web site activity including the timeliness of response and resolution of said interaction/transaction.*

Response: Community Health Solutions of Louisiana (CHS-LA) will host a robust website for the use of Members as well as providers. The site will contain information for Members including:

- Member Welcome Packet
- Education Information including:
 - Brochure entitled, “Tips for Choosing a Primary Care Physician (PCP)/Clinic.”
 - Brochure for parents/caregivers on the “The Importance of Well-Child Visits and Keeping Immunizations Up-to-Date.”
 - Tips for Making the Most of PCP Visits, to include:
 - Making a list of health needs prior to the appointment.
- Provider Directory
- Provider Search Engine with mapping/directions
- Important Contact Information
- Disease Education Information

To ensure that information is current, CHS-LA’s Webmaster will be informed when:

- Member educational materials are updated and/or change and need to be posted to the CHS-LA website.
 - New educational materials are created for the program and need to be added to the website.
 - Educational materials are out-of-date and need to be removed from the website.
 - A new posting is required by DHH, CHS-LA, or other appropriate entities.
-

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- Directories are updated and ready for posting.

The Webmaster uses a content management system (CMS), which is a collection of procedures used to manage work flow in a collaborative environment. These procedures can be manual or computer-based. The procedures are designed to:

- Allow for a large number of people to contribute to and share stored data.
- Control access to data, based on user roles (defining which information users or user groups can view, edit, publish, etc.).
- Aid in easy storage and retrieval of data.
- Reduce duplicate input.
- Improve the ease of report writing.
- Improve communication between users.
- Coordinate the process to approve all materials prior to posting online.

In the CMS, data can be defined in a myriad of ways such as documents, movies, pictures, phone numbers, and scientific data. CMSs are frequently used for storing, controlling, revising, semantically enriching, and publishing documentation. Serving as a central repository, the CMS increases the version level of new updates to an already existing file. Version control is one of the primary advantages of the system.

CHS-LA's procedures for monitoring inquiries from the web site, excluding transaction level interaction, is performed as follows:

- Request or inquiry comes into the CHS-LA website.
 - This information is entered into our Kayako Helpdesk software and converted into a project ticket.
 - Once in the Helpdesk system, each ticket is assigned to the appropriate department and an applicable priority severity level is set. Each department within the Helpdesk system has customizable automatic Service Level Agreement (SLA) processing based on severity. The SLA tools allow for automatic escalation as well as notification.
 - Each ticket is tracked by date and time for the staff assigned to handle to ensure that the inquiry is appropriately addressed and/or resolved in a timely and appropriate manner.
 - Once the request or inquiry has been resolved, the ticket is closed out and this is documented in the system.
-

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At the end of each month, reports including Average Response Time, Tickets per Department, and Tickets via Source are compiled and reviewed by the appropriate department manager. The Helpdesk system also includes capabilities for ad-hoc reporting as well as a real time dashboard so that continual monitoring and tracking of web site inquiries can be performed.

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Section L: **Customer Service (Section 11 of RFP)**

Requirement L.1: *Provide a narrative with details regarding your member services line including:*

1. *Training of customer service staff (both initial and ongoing);*
2. *Process for routing calls to appropriate persons, including escalation; The type of information that is available to customer service staff and how this is provided (e.g., hard copy at the person's desk or on-line search capacity);*
3. *Process for handling calls from members with Limited English Proficiency and persons who are hearing impaired;*
4. *Monitoring process for ensuring the quality and accuracy of information provided to members;*
5. *Monitoring process for ensuring adherence to performance standards;*
6. *How your customer service line will interact with other customer service lines maintained by state, parish, or city organizations (e.g., Partners for Healthy Babies, WIC, housing assistance, and homeless shelters); and*
7. *After hours procedures.*

Response:

Community Health Solutions of Louisiana's (CHS-LA) Member Services area is staffed by our fully owned affiliate, Premier Administrative Solutions, Inc. (Premier). Premier handles all Member Service inquiries except for those related to medical needs which are referred to and addressed by CHS-LA's Care Management team.

Training of CHS-LA's Member Service staff is based upon our primary mission of providing the highest level of customer service and incorporation of DHH's Person First philosophy in all interactions with Members, while exceeding performance standards for:

- Professionalism.
- Courtesy.
- Completeness and accuracy of information.
- Program metrics.
- Quality.

Immediately upon hiring, all Member Service staff participate in an extensive two week orientation and training program which consists of:

- Classroom training.
- Role play.

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- System navigation exercises.
- Shadowing a Member service staff member.
- Responding to live calls monitored by senior Member service staff member.

Classroom Training provides detailed information about:

- Corporate structure.
- Corporate vision and mission.
- Administrative guidelines.
- Goals, expectations and standards.
- Plan provisions.
- Policies and Procedures.
- Quality Assurance.
- Cultural competency training.
- Language Line.
- TTY Text telephone.
- HIPAA.
- Fraud and Abuse.

Role play sessions involve:

- Training staff assuming the role of Members.
- Training staff posing various real life call scenarios to newly hired staff.
- Newly hired staff responding to training staff as if they were Members.
- Review and critique of call.

System Navigation includes:

- System overview.
- System documentation.
- Screen by screen review of system fields and functionality.
- System navigation training exercises.

Responding to live calls monitored by senior Member Services staff member consists of:

- Newly employed staff taking live calls from Members.
- Senior staff member listening to call and assisting newly employed staff during call, whenever necessary.
- Senior staff member critiquing call, upon completion, with newly employed staff.

Member Service staff are extensively trained to answer questions raised by Members regarding:

- Program policies and procedures.
 - Program services.
-

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- Member eligibility.
- Carved-in Medicaid benefits.
- Carved-out Medicaid benefits.
- Procedures for obtaining benefits, including any authorization requirements.
- Cost sharing requirements.
- Information on PCPs or specialists, including those who speak languages other than English.
- Any restrictions on Member's freedom of choice among network providers.
- Which PCPs are accepting new patients.
- Process by which a Member may request a change in PCP.
- Emergency and after hours coverage.
- Resolution of service and/or medical delivery problems.
- Member grievances.

with an emphasis placed on:

- Member's Bill of Rights.
- Member's Right to Privacy.
- Compliance with HIPAA.
- Compliance with Federal and State laws and regulations.
- Treating all callers with dignity and respect.

Member Service staff are trained on and accept responsibility for ensuring the needs of all Members are met with regard to:

- Culture
- Ethnicity
- Race
- Religion
- Disability

in a manner that recognizes, values, affirms and respects the worth of the individuals and protects and preserves their dignity.

Member Service staff is required to sign a Confidentiality Agreement consistent with Federal and State Privacy Acts and HIPAA in addition to acknowledging that their calls will be monitored for quality assurance purposes.

Member Service staff receives ongoing training through department Supervisors/Managers. Training includes:

- On-going one-on-one mentoring and coaching.
 - Daily review of quality monitors.
-

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- Monthly Individual Counseling and Training Sessions (ICTS).
- Immediate notification of and training on program updates and changes.
- Assistance with questions and difficult calls.

Member Service staff receive additional on-going training and resource information from the Quality Assurance department including:

- Refresher Training Sessions.
- Monthly Newsletters.
- Continual Quality Monitoring.
- Intermittent Progress Reviews.
- Quality Monitor Rebuttal Process.

CHS-LA's process for routing calls to appropriate persons, including our call escalation process, starts with our primary goal of First Call Resolution. Our staff are extensively trained and experienced in responding to all questions in addition to identifying when a call should be redirected. A supervisor will assist with calls requiring escalation. Supervisors are trained, skilled, experienced and immediately available to respond to escalated situations.

If escalation to a supervisor is required, the staff member will:

- Advise Member that they will be transferring the call to a supervisor.
- Secure approval of transfer from Member.
- Initiate transfer through phone system call transfer option.
- Upon acceptance of call by supervisor, staff member will complete their part of the call.

If a caller requires to be connected to another Program Partner such as:

- State entity.
- Parish entity.
- City Organization.
- Partners for Healthy Babies.
- WIC.
- Housing assistance.
- Homeless shelter.

Our Member Service staff members have the ability to transfer the call or set up a conference call. In these instances, the Member Services staff member will:

- Advise Member that they will either be transferred to or conferenced in with one of the Program Partners.
-

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- Secure approval of transfer or conference from Member.
- Initiate transfer or conference through phone system call transfer/conference option
- Dial or select phone number for appropriate Program Partner
- If a transfer, upon acceptance of call by Program Partner, staff member will complete their part of the call. If a conference, staff member will continue with the call until completion.

CHS-LA is a high tech, process driven, paperless environment. Our web based applications make available the following types of information to our Member Service staff:

- Member demographics.
- Eligibility.
- Plan Provisions.
- Claims Information.
- History of prior calls.
- Program Specific Forms.
- Maps of Geographic Service Areas.
- Access to Mapping Search Engines.
- Provider Directories.
- Training Manuals.
- Policy and Procedures.
- Performance Metrics.

CHS-LA's process for handling calls from Members with Limited English Proficiency and persons with a hearing impairment includes a Spanish option, a Language Line option, and our TTY Text Phone. All callers are advised that their call is recorded and may be monitored for quality control purposes.

Members with Limited English Proficiency have the option to:

- Select Spanish prompt, routing the Member to a bilingual representative.
- Select prompt for all other languages, including Vietnamese. Member Service staff will utilize the Language line, providing interpretation in one hundred twenty five (125) languages, at no cost to the Member.

All Member Service staff members are trained in the operation of the TTY Text telephone and are able to assist callers with hearing impairment.

CHS-LA's monitoring process for ensuring quality and accuracy of information provided to Members is accomplished through our

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Quality Assurance and Performance Improvement Program (QAPI). QAPI monitors three to five percent (3-5 %), or more if contract requires, of all calls rating the below key performance areas:

- **Opening:** Cordially greets caller verifying identity per HIPAA guidelines.
- **Professional Courtesy:** Demonstrates the ability and willingness to assist.
- **Communication:** Speaks in clear tone using proper grammar.
- **Information:** Provides accurate and complete information.
- **Call Management:** Determines the need and takes ownership.
- **Call Tracking:** Documents accurately and completes notes.
- **Closing:** Recaps action to be taken. Asks if there is anything else we can do.

CHS-LA's monitoring process for ensuring adherence to performance standards is achieved by:

- Quality Audits.
- Identifying training opportunities.
- Offering feedback and coaching.
- Facilitating staff self-critique sessions.
- Tracking and reporting staff performance.
- Making recommendations for improvement.
- Ongoing training sessions.

Performance standards are monitored on a real time, daily, weekly, monthly and quarterly basis through an Automatic Call Distribution (ACD) system providing statistical data necessary to evaluate the efficiency and effectiveness of services provided as follows:

- Calls Offered.
 - Calls Queued.
 - Calls Delivered.
 - Calls Abandoned.
 - Abandonment Rate.
 - Busy Rate.
 - Average Contact length.
 - Average Speed of Answer.
 - Average Representative Talk time.
 - Service Level Percentage.
 - Schedule Adherence.
 - Member Service staff Available Time.
 - Member Service staff Unavailable Time.
 - Member Service staff Talk Time.
 - Call Reason.
 - Calls Transferred.
-

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Management analyzes statistical data to ensure adherence to performance standards and continuous process improvement.

As stated previously, CHS-LA's Member Service line interacts with other customer service lines maintained by state, parish, or city organizations directly through our automated call distribution system. CHS-LA also has the ability to provide prompts within our IVR for direct connection to these outside entities.

If a caller requires to be connected to another Program Partner such as:

- State entity.
- Parish entity.
- City Organization.
- Partners for Healthy Babies.
- WIC.
- Housing assistance.
- Homeless shelter.

our Member Service staff have the ability to facilitate a transfer or conference call.

CHS-LA's after hours (our normal hours are 7:00 am to 7:00 pm CST or CDT) procedure provides callers with a recording stating the following options:

- If this is a medical emergency, please call 911.
- If this is not a medical emergency, please press # to leave a message and a Member Service representative will return your call by close of next business day.
- If you do not wish to leave a message, please call back during normal business hours of 7:00 am to 7:00 pm CST.
- If you need to speak with a nurse please press # for our 24 hour nurse line.
- If you would like to leave a message for a nurse please press # and a nurse will return your call by close of next business day.

In the event of line trouble, emergency situations including natural disasters, or other problems, our phone system provides the flexibility for our Member Service staff to work from any phone with a standard 10-digit DID. Our service center phone system can be quickly updated to route calls to off-site agents who would answer calls via a cell phone or home phone. Our Emergency Management Plan is articulated in detail in Section M of our response.

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Section L: **Customer Service (Section 11 of RFP)**

Requirement L.2: *Provide member hotline telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as of January 1, 2011 for the most recent four (4) quarters, with data that show the monthly call volume, the trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system) and the monthly trends for the rate, if applicable.*

Response: Community Health Solutions of Louisiana (CHS-LA) has listed below Member Services telephone reports for our Medicaid managed care contract with the largest enrollment as of January 1, 2011 for the most recent four (4) quarters. These reports will indicate the monthly call volume and the trends for average speed of answer (defined by reaching a live voice, not an automated call system).

CHS-LA's current largest Medicaid managed care contract is with the state of South Carolina. Our program, South Carolina Solutions, currently has over 131,000 members enrolled. We have been providing managed care to Medicaid members in South Carolina since 2005. Prior to 2011, there were no contractual service level requirements for Member Services associated with this program. Therefore, we administered the program in accordance with industry standards of:

- Less than five per cent (5%) Abandonment Rate.
- Less than sixty (60) second Average Speed of Answer.
- Eighty per cent (80%) of calls answered in less than sixty (60) seconds.

In mid-January 2011, the following contractual service level requirements were implemented for this program:

- Less than three per cent (3%) Abandonment Rate.
- Less than thirty (30) second Average Speed of Answer.
- Ninety per cent (90%) of calls answered in less than thirty (30) seconds.

CHS-LA is committed to meeting Louisiana's required service levels as follows:

- Ninety-five per cent (95%) of calls answered within thirty (30) seconds or an automatic call pickup system.
 - No more than one percent (1%) of incoming calls receives a busy signal.
 - Average hold time of three (3) minutes or less.
 - Abandonment rate of less than five per cent (5%).
-

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If required service levels are not met for a given month, a Corrective Action Plan (CAP), will be implemented immediately to include, but not be limited to:

- Description of the problem/issue.
- Reasons for non-compliance.
- Actions/intervention to improve outcomes.

Column	Description
Calls Offered	The number of calls that entered our system for the program selected
Calls Q'ed	The number of calls associated with the program that were placed in queue.
Calls Del	The number of calls that were delivered to an agent for the program.
Calls Abandon	The number of calls associated with the program that were abandoned.
% Abandon	The percentage of total calls associated with the program that were abandoned.
Avg. Contact Length	The average duration of time for each contact during a month interval.
Avg. Agent Talk Time	The average duration of time the agent handled contacts associated with the program.
Avg. ASA	The average speed of answer represents how fast an agent picked up an inbound contact. For example, an agent took 25 seconds to answer a phone call contact.
Max Q Duration	The longest duration of time contacts associated with the program were in our system.
Total Duration	The total duration of time contacts associated with the program were in our system.
Total Agt. Duration	The total duration of time agents were handling contacts associated with the program.
Service Level	The Service Level percentage for this program is displayed according to the Service Level that is configured in our system.

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First Quarter 2011:

Contact Statistics By 1/1/2011 Client:
 Campaign And Month 12:00:00AM - 4590620
 3/31/2011 CHS Of
 12:00:00AM America

	Calls Offered	Calls Q'ed	Calls Del	Calls Abandon	% Abandon	Avg Contact Length	Avg Agent Talk Time	ASA	Max Q Duration	Total Duration	Total Agt Duration	Service Level
SOUTH CAROLINA SOLUTIONS (32408)												
2011-JAN	1814	1812	1750	62	3.42%	00:07:41	00:05:23	00:00:27	00:07:54	232:12:49	157:06:14	91.16%
2011-FEB	1742	1739	1686	53	3.05%	00:07:28	00:05:12	00:00:22	00:06:36	216:48:46	146:19:46	91.80%
2011-MAR	2492	2491	2417	74	2.97%	00:07:40	00:05:17	00:00:25	00:10:20	318:34:34	212:58:07	89.63%
SOUTH CAROLINA SOLUTIONS (32408) Totals:	6048	6042	5853	189	3.13%	00:07:37	00:05:18	00:00:25	00:10:20	767:36:09	516:24:07	90.71%
Report Totals:	6048	6042	5853	189	3.13%	00:07:37	00:05:18	00:00:25	00:10:20	767:36:09	516:24:07	90.71%

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Fourth Quarter 2010:

Contact Statistics By 10/1/2010 Client:
 Campaign And Month 12:00:00AM - 4590620
 12/31/2010 CHS Of
 12:00:00AM America

	Calls Offered	Calls Q'ed	Calls Del	Calls Abandon	% Abandon	Avg Contact Length	Avg Agent Talk Time	ASA	Max Q Duration	Total Duration	Total Agt Duration	Service Level
SOUTH CAROLINA SOLUTIONS (32408)												
2010-OCT	1568	1567	1507	60	3.83%	00:06:35	00:04:23	00:00:29	00:10:26	172:13:05	109:56:24	89.69%
2010-NOV	1655	1654	1589	65	3.93%	00:07:06	00:04:59	00:00:33	00:44:44	195:58:14	132:01:56	88.40%
2010-DEC	1546	1546	1455	91	5.89%	00:07:25	00:04:59	00:00:30	01:33:28	191:02:45	121:01:44	89.75%
SOUTH CAROLINA SOLUTIONS (32408) Totals:	4769	4767	4551	216	4.53%	00:07:02	00:04:47	00:00:31	01:33:28	559:14:04	363:00:04	89.26%
Report Totals:	4769	4767	4551	216	4.53%	00:07:02	00:04:47	00:00:31	01:33:28	559:14:04	363:00:04	89.26%

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Third Quarter 2010:

Contact Statistics By 7/1/2010 Client:
 Campaign And Month 12:00:00AM - 4590620
 9/30/2010 CHS Of
 12:00:00AM America

	Calls Offered	Calls Q'ed	Calls Del	Calls Abandon	% Abandon	Avg Contact Length	Avg Agent Talk Time	ASA	Max Q Duration	Total Duration	Total Agt Duration	Service Level
SOUTH CAROLINA SOLUTIONS (32408)												
2010-JUL	1634	1634	1563	71	4.35%	00:06:45	00:04:40	00:00:30	00:06:46	183:52:14	121:34:09	86.98%
2010-AUG	1910	1905	1821	87	4.57%	00:06:29	00:04:26	00:00:35	00:11:59	206:33:38	134:41:08	86.49%
2010-SEP	1861	1860	1771	89	4.78%	00:06:46	00:04:25	00:00:36	00:17:18	209:39:52	130:27:21	87.13%
SOUTH CAROLINA SOLUTIONS (32408) Report Totals:	5405	5399	5155	247	4.57%	00:06:40	00:04:30	00:00:34	00:17:18	600:05:44	386:42:38	86.86%

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Second Quarter 2010:

Contact Statistics By 4/1/2010 Client:
 Campaign And Month 12:00:00AM - 4590620
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	Calls Offered	Calls Q'ed	Calls Del	Calls Abandon	% Abandon	Avg Contact Length	Avg Agent Talk Time	ASA	Max Q Duration	Total Duration	Total Agt Duration	Service Level
SOUTH CAROLINA SOLUTIONS (32408)												
2010-APR	1653	1651	1606	46	2.79%	00:06:28	00:04:55	00:00:25	00:06:26	177:59:17	131:47:11	90.90%
2010-MAY	1672	1669	1617	52	3.12%	00:06:45	00:05:09	00:00:23	00:15:25	187:57:04	138:58:51	92.50%
2010-JUN	1873	1866	1792	74	3.97%	00:07:25	00:05:32	00:00:28	00:12:57	231:24:56	165:27:13	89.68%
SOUTH CAROLINA SOLUTIONS (32408) Totals:	5198	5186	5015	172	3.32%	00:06:54	00:05:13	00:00:25	00:15:25	597:21:17	436:13:15	90.98%

Report Totals: 5198 5186 5015 172 3.32% 00:06:54 00:05:13 00:00:25 00:15:25 597:21:17 436:13:15 90.98%
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Section L: **Customer Service (Section 11 of RFP)**

Requirement L.3: *Describe the procedures a Member Services representative will follow to respond to the following situations:*

- *A Member has received a bill for payment of covered services from a network provider or out-of-network provider;*
- *A Member is unable to reach her PCP after normal business hours;*
- *A Member is having difficulty scheduling an appointment for preventive care with her PCP; and*
- *A Member becomes ill while traveling outside of the GSA.*

Response:

The procedure that a Community Health Solutions of Louisiana (CHS-LA) Member Services representative will follow to respond to a Member if a Member has received a bill for payment of covered services from a network provider or out-of-network provider, is:

- Confirm Member's identity.
- Confirm Member's eligibility.
- Secure Member's claim information.
- Advise Member if provider is a network or out-of-network provider.
- Advise Member of plan provisions, coverage and any Member cost sharing.
- Advise Member that CHS-LA will contact provider to research basis of patient billing and to educate the provider on claim submission processes, if applicable.
- Ask Member if there is anything else we can assist with.
- Close and document the call.
- Refer case to Provider Services program to ensure providers are complying with contractual requirements regarding Members' cost sharing limits.

The procedure that a CHS-LA Member Services representative will follow to respond to a Member if a Member is unable to reach their PCP after normal business hours is:

- Confirm Member's identity.
- Confirm Member's eligibility.
- Determine if the Member considers this to be a medical emergency and if so, advise the Member to call 911.
- Confirm that Member is calling the correct after-hours number

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for their provider.

- Offer to transfer Member to our 24/7 Nurse Line, if applicable.
- Ask Member if there is anything else we can assist with.
- Close and document the call.
- Refer case to Provider Services program to ensure providers are complying with contractual requirements regarding after-hours coverage and access.

The procedure a CHS-LA Member Services representative will follow to respond to a Member if a Member is having difficulty scheduling an appointment for preventative care with their PCP is:

- Confirm Member's identity.
- Confirm Member's eligibility.
- Identify Member's PCP.
- Secure details of actions Member has taken and PCP's reported response.
- Advise Member that we will contact their PCP and call them back.
- Call Member's PCP to gain pertinent information.
- Request PCP contact Member today to schedule an appointment, if applicable.
- Contact Member to advise outcome of discussion with PCP.
- Follow up with Member within 2 business days to confirm PCP has made contact.
- If PCP has not made contact, Member Services staff will contact CHS-LA's Executive Director to trigger an immediate Provider Relations and/or CHS-LA's Medical Director intervention.
- Ask Member if there is anything else you can assist with.
- Close and document the calls.
- Regardless of outcome, refer case to Provider Services program to ensure providers are complying with contractual requirements regarding appointment availability.

The procedure a CHS-LA Member Services representative will follow to respond to a Member if a Member becomes ill while traveling outside of the GSA is:

- Confirm Member's identity.
 - Confirm Member's eligibility.
 - Determine if Member considers this to be a medical emergency and if so, advise the Member to call 911.
 - Transfer Member to Care Management Registered Nurse for referral, if applicable.
-

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- Transfer Member to our 24/7 Nurse Line, if applicable.
- Ask Member if there is anything else you can assist with.
- Close and document the call.
- Refer case to Care Management to ensure appropriate follow-up care and transfer of medical records occurs.

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Section L: **Customer Service (Section 11 of RFP)**

Requirement L.4: *Describe how you will ensure culturally competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.*

Response: Community Health Solutions of Louisiana (CHS-LA) will ensure culturally competent service to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals, and protects and preserves the dignity of each through extensive training of all CHS-LA staff and individual acceptance of responsibility for ensuring the needs of all Members are met with regard to:

- Culture.
- Ethnicity.
- Race.
- Religion.
- Disability.

Cultural competency training is not only emphasized during new employee orientation and training, but continually reinforced during:

- One-on-one mentoring and coaching.
- Daily Review of quality monitors.
- Monthly Individual Counseling and Training Sessions (ICTS).
- Intermittent Progress Reviews.
- Monthly Newsletters.
- Annual Refresher Training.

The Objectives of CHS-LA’s Cultural Competency Training are:

- Compliance with DHH’s Person First policy.
 - Increased awareness of the major shifts in the US population.
 - Understanding that each Member is unique.
 - Understanding the importance of speaking clearly and in a manner the Member will understand.
 - Recognition of factors that contribute to building strong relationships with Members.
 - Appreciation that Members’ ethnicity and cultural background have strong influence on their willingness to adhere to CHS-LA’s advice.
-

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- Understanding that the phrasing of questions/comments sets the stage for a positive on-going relationship.

CHS-LA facilitates cultural competency to Members with disabilities through:

- Compliance with DHH's Person First policy.
- Cultural Competency Training.
- Access to TTY Text telephone.
- Partnership with community-based advocacy groups.

CHS-LA ensures culturally competent services through:

- Quality Audits that include random call samples.
- Monitoring of live calls.
- Identifying training opportunities.
- Offering feedback and coaching.
- Facilitating staff self-critique sessions.
- Tracking and reporting staff performance.
- Making recommendations for improvement.
- Ongoing training sessions.

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Section L: **Customer Service (Section 11 of RFP)**

Requirement L.5: *Describe how you will ensure that covered services are provided in an appropriate manner to Members with Limited English proficiency and Members who are hearing impaired, including the provision of interpreter services.*

Response: Community Health Solutions of Louisiana (CHS-LA) will ensure that covered services are provided in an appropriate manner to Members with Limited English proficiency and Members with a hearing impairment, including the provision of interpreter services through the following process:

- At the time of contracting, CHS-LA gathers information regarding languages spoken and interpretive service available at that provider's office(s).
- Information will be shared with the Enrollment Broker and CHS-LA's Member Services staff to assist the Member in selecting a PCP.
- CHS-LA will provide all network providers with information on interpretive services as well as services available to assist Members with a hearing impairment.
- CHS-LA will confirm the Member's primary language or if they have a hearing impairment during the Welcome Call process and document the Member's record accordingly.
- CHS-LA will then determine, through provider directory review, if the Member's assigned PCP provider can accommodate the Member's Limited English proficiency or hearing impairment. If review of the Provider Directory is inconclusive, CHS-LA will contact the PCP directly to ascertain their capacity to meet the Member's language requirements.
- If the Member is assigned to a PCP that cannot accommodate their communication/language needs, we will facilitate a transfer of the Member to a PCP who is able to do so. If there is not a PCP in the Member's geographic area that can accommodate the Member's communication/language needs, we will work with the assigned PCP to ensure that interpretation and communication services are made available.
- All of CHS-LA's marketing materials, printed publications, website, and Member education materials will include a statement advising Members that these materials will be made

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available to them in their primary language, as well as Braille and audio tapes, upon request, including instructions on how to request such service.

- CHS-LA will confirm languages spoken as a primary language for 200 or more Members within a GSA and have materials available in these languages as well as alternate communication mechanisms, such as Braille and audio tapes, to provide to Members upon request. All multi-page written Member materials will notify Members that real-time oral interpretation is available for any language at no expense to them as well as instructions on how to access these services.
- CHS-LA, upon request, will provide alternative forms of communication for persons with visual, hearing, speech, physical or developmental disabilities at no expense to the Member to include, but not be limited to:
 - Materials in braille
 - Audio tapes
 - Materials translated in various languages
 - Materials at lower than a sixth-grade reading level
 - Translator services
 - Coordination with state services such as Louisiana Commission for the Deaf and Louisiana Assistance for the Blind
- CHS-LA's process for handling calls from Members with Limited English proficiency or with a hearing impairment includes a Spanish option, Language Line option, and our TTY Text Phone. All callers are advised that their call is recorded and may be monitored for quality control purposes.
 - Members with Limited English Proficiency have the option to:
 - Select Spanish prompt, routing the Member to a bilingual representative.
 - Select prompt for all other languages, including Vietnamese. In these instances, Member Services and Care Management staff will utilize the Language line, providing interpretation in one hundred twenty five (125) languages at no cost to the Member.
 - All Member Services and Care Management staff members are trained in the operation of the TTY Text telephone and are able to assist callers with hearing impairment.

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Section M: **Emergency Management Plan (Section 3 of RFP)**

Requirement M.1: *Describe your emergency response continuity of operations plan. Attach a copy of your plan or, at a minimum, summarize how your plan addresses the following aspects of pandemic preparedness and natural disaster recovery:*

- *Employee training;*
- *Identified essential business functions and key employees within your organization necessary to carry them out; Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;*
- *Communication with staff and suppliers when normal systems are unavailable;*
- *Specifically address your plans to ensure continuity of services to providers and members; and*
- *How your plan will be tested.*

Response:

Community Health Solutions of Louisiana (CHS-LA) Emergency Response Continuity of Operations Plan is designed to address pandemic preparedness and natural disaster recovery through a detailed business continuity and disaster management plan. Emphasis is placed on ensuring the ongoing provision of health services in an epidemic, disaster or manmade emergency including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies.

CHS-LA'S plan meets the following characteristics of emergency preparedness plans:

1. Capability of being maintained at a high level of readiness.
2. Capability of implementation with or without warning.
3. Ability to achieve operational status no later than eight (8) hours after activation.
4. Ability to sustain operations for at least fourteen (14) days.
5. Ability to leverage multiple existing locations or field infrastructures.

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Our plan addresses employee training by mandating that each individual employee receives a copy of our Employee Emergency & Safety Training Manual (EESM). The EESM serves to educate and familiarize employees with the potential hazards within their facility and the surrounding region and the appropriate employee response when faced with these hazards. This EESM is considered to be a current collection of Policies and Procedures detailing employee response to the emergencies identified within.

CHS-LA essential business functions include:

- Member Services.
- Provider Services.
- Claims.
- Care Management.
- Mail Room Operations.
- Information Technology.

Our essential business function needs are evaluated by designated key employees assigned to the Disaster Recovery Team (DRT), as well as additional staff members as requested by the DRT. The EESM is periodically reviewed and updated, as necessary, during our bi-annual Disaster Plan Meetings which are attended by all DRT members.

The Chart below illustrates CHS-LA's five main essential functions identified as having the highest priority to continuity maintenance in the event a hazard may impact CHS-LA.

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Hazard Identifiers and Durations (In Business Days)		A Member/ Provider Services	B Claims Processing	C Mailroom Functions	D Carel Manage- ment	E Information Technology
1	Short Term – Minimal response required as impact is department localized or anticipated to be quickly resolved	Less than 1 business day of inoperable phone service expected.	Less than 2 business days of claims processing inability anticipated	Less than 2 business days of inability to send our mail	1 business day	1 business day
2	Mid Term – Serious impact on normal operations, a coordinated response is required for a number of days	Over 24 hours but less than 48 hours of loss of telephone service is anticipated	3 business days of inability to process claims	Greater than 2 business days with the exception of the ability to print within 2 business days	2 business days	2 business days
3	Long Term – Major impact on normal operations for an extended duration	At least 48 hours loss of phone service is assumed	At least 5 business days of inability to process claims is anticipated	5 or more business days	4 business days	4 business days

Not all disasters will be predictable or allow reaction time as illustrated in the chart above. Immediate responses may be necessary under these situations.

Our plan identifies key employees as follows:

- DRT and Disaster Planning Coordinators, listing their titles and primary responsibilities in the planning, coordination and testing of CHS-LA’s Disaster Management Plan.
- DRT, listing the titles of all DRT members and their respective responsibilities.
- A contingency plan for covering the stated essential business functions in the event these key employees are incapacitated or their primary workplace is unavailable.

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Communication to staff and suppliers when normal systems are unavailable would be addressed as follows:

CHS-LA Staff:

- A Disaster Level is immediately assigned by our Chief Operations Officer during a critical situation.
- Once assigned plan level is communicated, employees and Disaster Management Team members are to follow current CHS-LA's Policies and Procedures to safeguard themselves and CHS-LA assets.
- Internal email blasts and Automatic Notification System messages are then sent to all employees on a daily basis advising them of the status of the impending hazard and, on an increased frequency, as the storm/hazard approaches, the messages will provide:
 - Updates and direction on continuation of service in the event of an occurrence and subsequent evacuation to all employees with updates on status level of Emergency Plan.
 - Reference to our website for constant updates to include guidelines on what to do prior to, during, and after a natural or man-made disaster.

CHS-LA Suppliers:

- The Emergency Management Coordinator shall be responsible for communicating to CHS-LA's supplier and service companies, both within and outside the potentially impacted area, to advise them of our plan and needs prior to, during and after the disaster and to provide backup or restoration services until the CHS-LA has resumed normal operations. Email updates, as well as our emergency contact number(s), will serve as primary channels for on-going communications.
- To ensure continuity of service to members and providers, each Disaster Management Team member will be required to perform specific actions to mitigate the situation. The Disaster Management Team is comprised of all Department Heads. This Team will directly coordinate the actions of all employees and their responsibilities in the event that a hazard or disaster is presented, using the Disaster Management Plan as their guide. They will also assist other Disaster Management Team members as needed.

Further mitigating steps focused on continuity of services include:

- Evaluating the need for relocation of potentially impacted staff to another of our corporate locations.
-

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- Notifying non-impacted sites that they would begin to absorb the functions of the potentially impacted site(s).
- Routing of calls to one of our alternate corporate sites.
- Evaluating the need to augment employees at the non-impacted site(s) with employees from potentially impacted site(s) to provide back-up and intensive training, to further ensure continuity of service.
- Alternatively, as all of our sites are provided with relocation kits which include a laptop with preloaded software and a pre-paid cell phone, we have the ability to route calls to off-site employees who would answer calls via cell phones or home phones. Employees who are unable to relocate to one of our other corporate locations would be relocated to other designated safe locations with an internet connection and sufficient bandwidth to access our systems, allowing for continued seamless service.

Our continuity plan also includes the following:

- A registry of healthcare providers within the PCP network (MD, nurse practitioner, etc.) who are willing to volunteer in state operated Special Needs shelters.
- Identification of Members with special healthcare needs for enhanced coordination of services with state agencies and assistance in evacuation of these Members. Identification of special healthcare needs is made through claims data mining, health risk assessments, and Member Welcome Calls.
- Partnering with DHH and their contracted networks in adjoining states to service our Members.
- Use of our Document Management System (DMS) to allow providers access to Electronic Health Records (EHR) in a secured environment, to provide health care providers access to Members' health history and to receive history of care provided during evacuation.

All of the above would allow our operations to proceed as normal; this process would be sustained for as long as necessary to allow for repatriation.

CHS-LA annually tests our Emergency Response Continuity of Operations Plan through:

- Simulated disasters and lower level failures of our systems.
 - A bi-annual Disaster Management Team meeting to conduct an "Assessment of Hazard Impacts" analysis within their own departments, using the Hazard Analysis Chart.
-

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- Upon identification and prioritization of potential risks, the Disaster Management Team shall:
 - Determine potential short and long-range solutions.
 - Decide upon the most appropriate primary and secondary solutions.
 - Test and evaluate these solutions for effectiveness.
 - Include these solutions in the Disaster Management Plan, and related testing and training programs.

- All original records of the processes used to compile the information resulting in these policies and procedures shall be retained by the Emergency Management Coordinator, in a location separate from the Disaster Management Plan. These records shall include the names and positions of all appropriate persons involved in the continued planning and writing of the plan.

- The Emergency Management Coordinator will also maintain lists and information vital to CHS-LA and its employees to assist in disaster planning, mitigation and recovery efforts.

- Upon conclusion of their bi-annual meeting, the Disaster Management Team develops and presents an updated Hazard Analysis Report, which details any changes that will need to be made to the Disaster Management Plan. This report shall serve as the overall result of the meeting and be distributed to all Disaster Management Team members. Based on this Hazard Analysis Report, the Disaster Management Plan is updated, as necessary, and distributed to all employees.

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Section M: **Emergency Management Plan (Section 3 of RFP)**

Requirement M.2: *Describe your plan in the following Emergency Management Plan scenario for being responsive to DHH, to Members who evacuate, to network providers, and to the community.*

- *You have thirty thousand (30,000) or more CCN Members residing in hurricane prone parishes. All three GSAs include coastal parish and inland parishes subject to mandatory evacuation orders during a major hurricane. A category 5 hurricane is approaching, with landfall predicted in 72 hours and parishes within the GSA are under a mandatory evacuation order. State assisted evacuations and self-evacuations are underway. Members are evacuated to or have evacuated themselves to not only all other areas of Louisiana, but to other States.*
- *Your provider call center and Member call center are both located in Baton Rouge and there is a high likelihood of high winds, major damage and power outages for 4 days or more in the Baton Rouge Area (reference Hurricane Gustav impact on Baton Rouge). It is expected that repatriation of the evacuated, should damages be minimal, will not occur for 14 days. If damage is extensive, there may be limited repatriation, while other Members may be indefinitely relocated to other areas in Louisiana or other states.*

Response:

CHA-LA recognizes that timely response to the needs of DHH, our Members, Network Providers, and the community, requires early detection and tracking of all natural disasters. Clearly the most likely natural disaster to affect Louisiana is hurricanes, but recent flooding in Louisiana and devastating tornados throughout the Southeast and Midwest clearly indicate the importance of CHS-LA closely monitoring and being responsive to any potential disaster situation that arises. Based upon the scenarios given, early hurricane tracking ensures having the appropriate level of our plan in place to deal with the potential damage and continuity challenges that will confront our Members, Providers, and our company. At CHA-LA, communications and emergency management are synonymous.

Steps that CHS-LA will take in the face of an approaching hurricane are:

- All approaching storms are tracked via NOAA Weather Radio and Cable weather networks and assigned a Disaster Level by

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- our Chief Operations Officer as we secure real time information.
- Announcements are made to all CHS-LA staff by our Disaster Management Team when an approaching hurricane allows for preparation and preplanned actions of Team Members upon plan level activation.
- Once assigned plan level is communicated, all CHS-LA staff and Disaster Management Team Members are to follow current Company Policies and Procedures to safeguard themselves and Company assets.

In the event of the first (1st) scenario, communication with the following entities will be initiated to ensure a coordinated effort:

- DHH
- Provider Network Associations
- Contracted Hospitals/Clinics
- Specialty networks
- Office of Public Health
- Center for Community Preparedness
- Vendors/Service Providers in the impacted areas
- FEMA
- Parish Homeland Security contacts
- State agencies that serve disabled or vulnerable populations such as individuals with mental illness and/or developmental disabilities (for assistance during and support upon relocation)

Tools of communication to be used include:

- Email blasts to Members, providers, vendors, parish emergency preparedness contacts, and state agencies on the status of the pending hurricane and our intended response leading up to impact.
 - The messages will provide updates and direction on continuation of service in the event of an occurrence and subsequent evacuation and reference to our website for constant updates to include guidelines on what to do pre and post a hurricane.
- Conference calls (as permitted) with network provider associations, hospitals, clinics, specialty provider's networks and State agencies to discuss plan of action pre and post disaster.
- Internal email blasts to all CHS-LA employees with updates on status level of Emergency Plan.
- Public Service Announcements--- Scripted messages via Radio Networks advising Members and providers to continue to call

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our toll free numbers located on their Membership cards.

- Press conferences at a specific and easy-to-access location, as frequently as the demand and situation require.

In advance of any potential mandatory evacuation of our Baton Rouge office due to a hurricane, CHA-LA would take the following mitigating steps:

- Our Baton Rouge office employees will be asked to follow Emergency Plan policy and procedure for relocation, which may include relocation to another of our office locations.
- Immediately notify corporate staff located at the non-impacted sites that they will begin to absorb the functions of the potentially impacted facility and begin routing of calls to one of our alternate sites in St. Petersburg, Florida or Columbia, South Carolina.
- Evaluate the need to augment employees at the non-impacted site(s) with employees from potentially impacted site(s) to provide back-up and intensive training, to further ensure continuity of service to our Members and providers.
- Alternatively, as all of our sites are provided with a relocation kits which include a laptop with preloaded software and a pre-paid cell phone, we have the ability to route calls to off-site employees who would answer calls via cell phones or home phones. Employees, who are unable to relocate to one of our other locations, would be relocated to other designated safe locations with an internet connection and sufficient bandwidth to access our systems, allowing for continued seamless service.

All of the above would allow our Member Services and Provider Services operations to proceed as normal; transparent to any Members and network providers. This process would be sustained for as long as necessary to allow for repatriation.

CHA-LA is able to support this type of response due to the flexibility of our call centers phone system infrastructure, which offers both system redundancy within the application as well as geographical redundancy with data centers. Our phone system provides the flexibility for our call representatives to work from any phone with a standard 10-digit DID.

Additionally, our data center is housed at an off-site facility which provides our company with a managed colocation, enterprise hosting, reliable bandwidth and Disaster Recovery Solutions. This includes access to facility office space (including phones, fax, copier/printer and

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dedicated work space area with tables and chairs in any of their locations) available within four (4) hours of a disaster declaration, if required as a relocation site.

As CHS-LA approaches an emergency response, it also places high emphasis on risk management across multiple spheres- clinical, fiscal, and professional. While CHS-LA is clearly focused on ensuring access to care in the case of large-scale displacements, we also want to minimize any liability to the State or our providers.

In addition to contracting with independent practitioners, RHCs, and FQHCs, it is CHS-LA's intent to contract with large hospital systems for both primary and specialty care. These systems have clinics, hospital facilities, and specialty care services available in multiple sites; they have consistent professional liability coverage for all sites therefore they do not face risk if they allow their displaced providers to practice out of their functioning sites. Due to professional liability associated with requiring providers to allow other providers to practice out of their offices, we feel the State would be better served to rely upon large systems to serve this function.

It is CHS-LA's intent to implement language in our subcontract with those providers who have indicated a willingness to allow displaced providers, within their system, to practice in multiple sites.

Information regarding points of care in the case of a large-scale displacement would be shared with Members via blaster calls and CHS-LA's website and our Member Services staff and 24 /7 Nurse Line staff would be informed and able to respond to any inquiries on inbound calls.

For Out of state displacements:

- CHS-LA would instruct its Members, through Member handbook, blaster calls, and website, that, in the case of an out-of-state displacement, they should seek primary care through an urgent care facility and emergency care through an Emergency Room.
- For Members with chronic conditions, they, or the provider who has seen them, should contact CHS-LA's Care Management department for referral numbers and to ensure ongoing access to appropriate care.
-

CHS-LA's website and our Member Services staff and 24/7 Nurse Line staff would be informed and able to respond to any inquiries on inbound calls.

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Section N: **Grievances (Section 12 of RFP)**

Requirement N.1: *Provide a flowchart (marked as Chart C) and comprehensive written description of your Member grievance process, including your approach for meeting the general requirements and plan to:*

- *Ensure that the Grievance System policies and procedures, and all notices will be available in the Member's primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal;*
- *Ensure that individuals who make decisions on Grievances have the appropriate expertise and were not involved in any previous level of review; and*
- *Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member's health. As part of this process, explain how you will determine when the expedited process is necessary.*

Include in the description how data resulting from the grievance system will be used to improve your operational performance.

Response: Community Health Solutions of Louisiana (CHS-LA) has an established procedure for receiving and processing all complaints, grievances and appeals in accordance with 42 CFR Section 438.400, et. Seq. Compliance with this regulation includes facilitating Member access or their designated representative to the Louisiana State's Fair Hearing Process and routine reporting of compliance, grievances and appeals to the Louisiana DHH. CHS-LA will obtain approval of these policies and procedures from the Louisiana DHH within thirty (30) days upon establishment of an executed contract.

CHS-LA will maintain a monitoring system to receive and respond in a timely manner to complaints and grievances, and, when appropriate, inform Members of their rights to submit an appeal and have access to the Louisiana State Fair Hearing Process. The information and instructions for initiating this process will be in the CHS-LA Member materials, including the Member Welcome Packet and the Member Handbook, as well as on the CHS-LA website. CHS-LA will also include the toll-free contact line for this process on the CHS-LA issued identification card.

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The specific information and directions for the process, including associated forms will be available in the Member's primary language and will meet the state's reading level requirement. Translation services and a toll-free line with TTY/TDD will be available. Members will also be informed that CHS-LA Member Services staff can assist them in the filing of a complaint, grievance or request for State Fair Hearing, if so desired, and that an expedited process will be used when health needs require doing so.

Complaints, grievances and appeals will be accepted orally or in writing. CHS-LA staff members receive education regarding the complaint process upon hire and annually thereafter. Part of this education is focused on complaint resolution upon receipt. Every effort is made to resolve complaints or grievance at the time they are verbally received.

Each instance/complaint will be logged by a Member Services staff member. If the Member Services staff member can assist the Member in resolving the issue, this outcome will also be logged. All information - both related to resolved and open issues - will be logged upon receipt and provided to the CHS-LA Grievance System Coordinator (GSC) on a daily basis.

The GSC is a member of the Quality Management Department and is clinically qualified as well as operationally knowledgeable to make determinations regarding appropriately expediting concerns/grievances that may impact quality of care.

The GSC will review each complaint, grievance or appeal and forward to the appropriate designated staff member for review and further research, if required. Any issue of a high or aggravated nature or that could negatively affect a Member's health status will be forwarded immediately indicating the need for prompt attention by clinical/medical Community Health Solutions of America (CHS) senior staff members, including CHS' Vice President of Clinical and Quality Operations or Chief Medical Officer.

The goal is always to reach resolution at the time the complaint is received and verbally confirm satisfactory resolution with the reporting source. When that is not possible, written notification of resolutions to the complaint source regarding each matter, will be completed as expeditiously as possible. (Please see Chart C for the exact process that CHS-LA will utilize.) Each complaint, grievance or appeal will be handled as distinct and unique event and specific attention will be

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placed upon ensuring that the decision-maker has appropriate education and expertise to fairly evaluate the Member's situation. In addition, the decision makers will not be utilized for multiple events involving the same Member. When a complaint or appeal related to denial of services, DHH approved Utilization Management policies will be implemented to ensure appropriate timeframes, processes and procedures are followed.

The GSC will participate on the CHS-LA's Quality Management Committee (QMC). A review of any and all complaints and associated determinations will be done at least quarterly to coincide with the reports provided to DHH. Trends will be monitored so that information from occurrences can be utilized to identify improvement opportunities which may include:

- Improved access to care.
- Provider education.
- Member education.
- Changes to CHS-LA policies and procedures.

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Section N: **Grievances (Section 12 of RFP)**

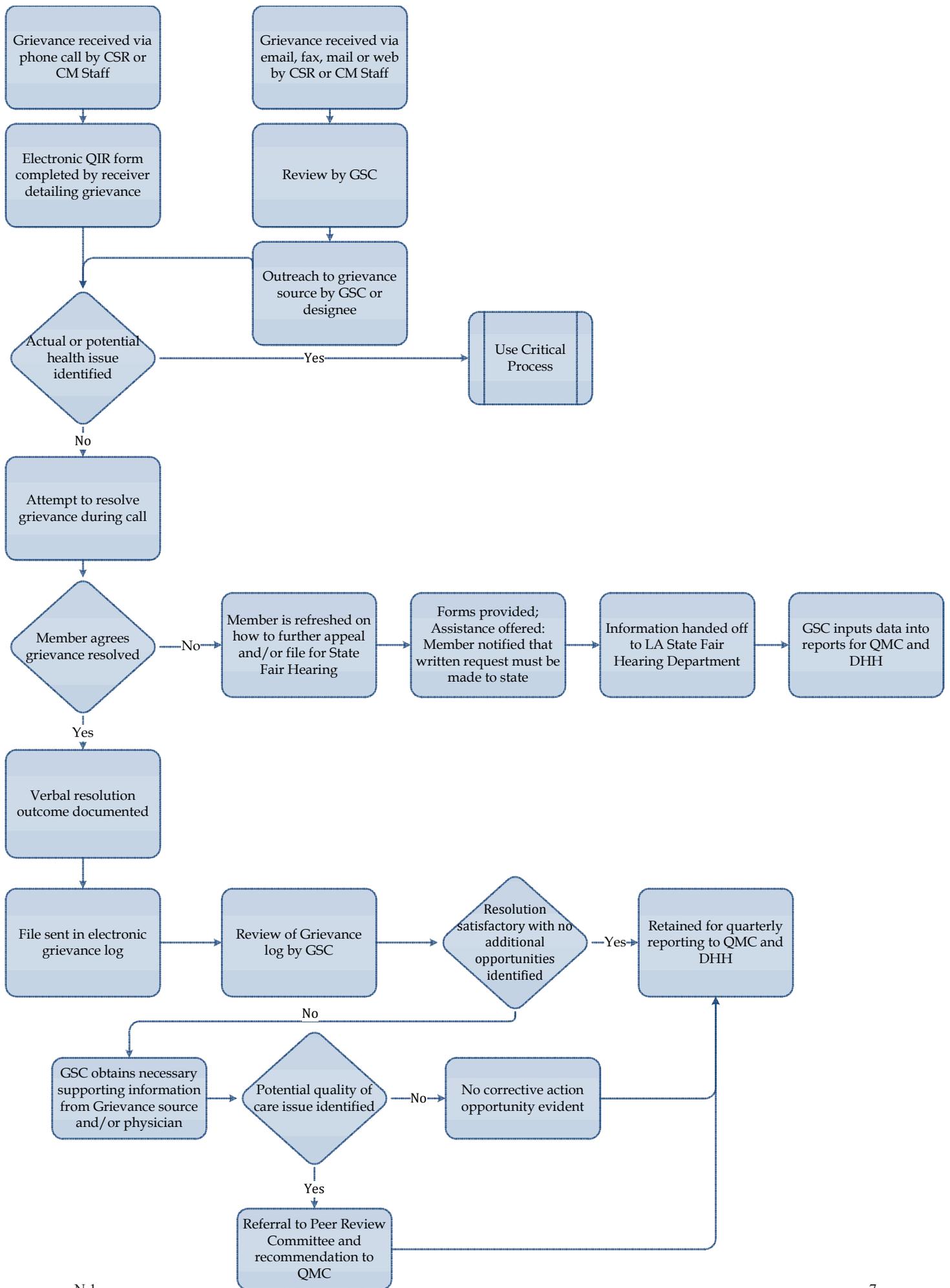
Requirement N.1: *Provide a flowchart (marked as Chart C) and comprehensive written description of your Member grievance process, including your approach for meeting the general requirements and plan to:*

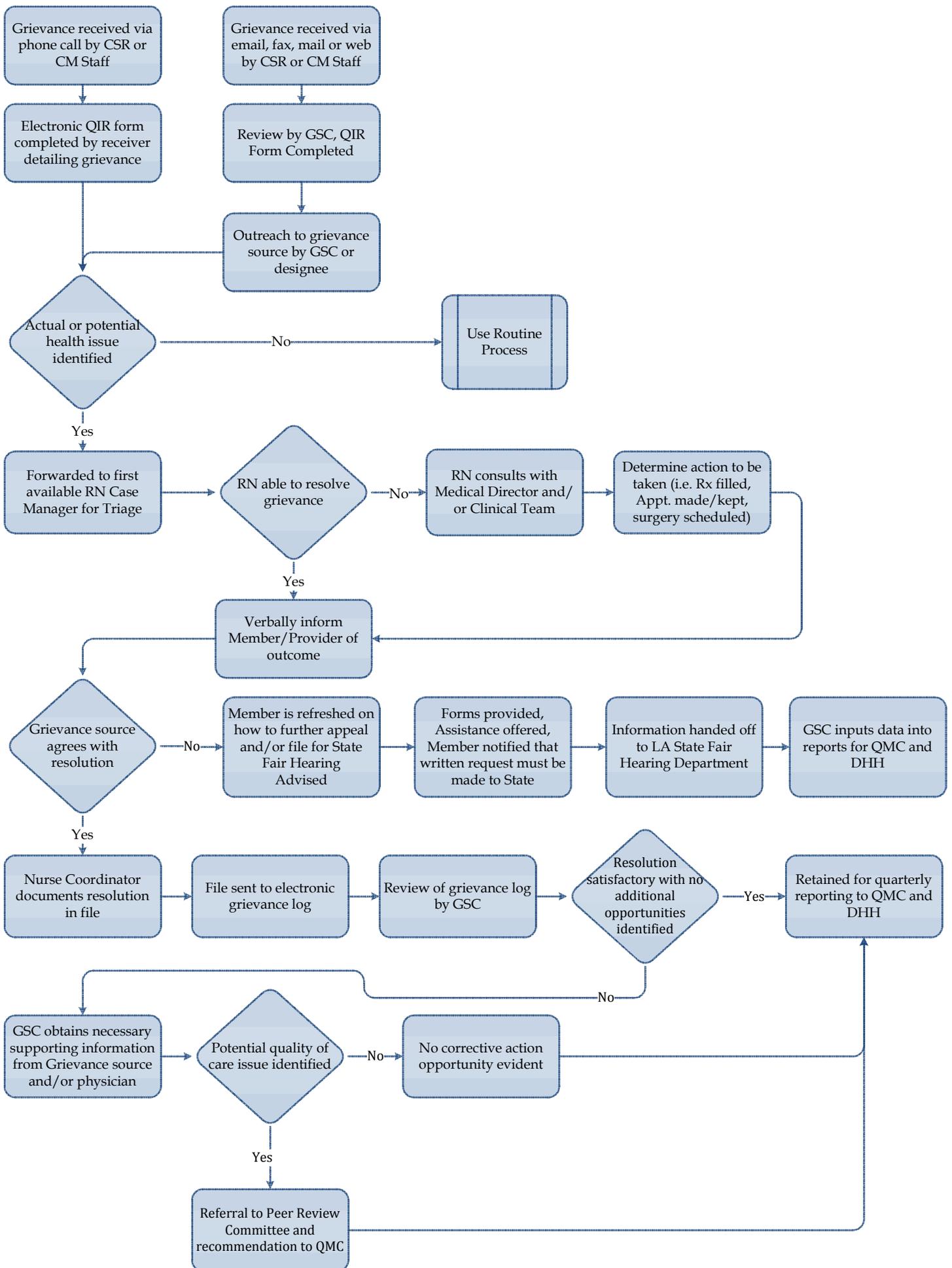
- *Ensure that the Grievance System policies and procedures, and all notices will be available in the Member's primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal;*
- *Ensure that individuals who make decisions on Grievances have the appropriate expertise and were not involved in any previous level of review; and*
- *Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member's health. As part of this process, explain how you will determine when the expedited process is necessary.*

Include in the description how data resulting from the grievance system will be used to improve your operational performance.

Attachment 1: Chart C: Member Grievance Process Flowchart

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Section O: **Fraud & Abuse (Section 15 of RFP)**

Requirement O.1: *Describe your approach for meeting the program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Discuss your approach for meeting the coordination with DHH and other agencies requirement.*

Response: The Executive Committee of Community Health Solutions of America (CHS), chaired by the Chairman of the Board, has established an organization-wide Compliance Plan to prevent, detect, report and implement corrective action for any suspected fraud and abuse in administration and delivery of services. This plan is built upon state and federal requirements with an overarching goal to protect the integrity of the health plans we administer, the associated providers , and the enrolled members. We have established a culture of commitment to compliance and program integrity. CHS uses the definitions of Compliance found in 42 CRF 455.2 which, in that context, pertain to Medicaid, but are applicable to any business undertaking by CHS.

In order to achieve this goal, CHS’s Executive Committee designated the Quality Management Committee (QMC) to implement the Compliance Plan. The Compliance Plan, which will apply to all business aspects in Louisiana, focuses on the following objectives:

- Ensure that organizational business practices are established to prevent fraud and abuse. Each department within CHS and Community Health Solutions of Louisiana (CHS-LA) has fundamental policies, practices and activities geared to prevent the occurrence of fraud or abuse.
- Educate members/enrollees, providers, and staff regarding our working Compliance Plan in order to prevent and/or avoid waste, abusive or fraudulent behavior.
- Review the activities CHS-LA, its participating providers, members/enrollees, business associates, covered entities, and staff in order to detect incidents involving suspected fraudulent or abuse activity with regard to health care or administrative services. Investigate such incidents in an efficient, effective and objective manner.
- Resolve such incidents effectively and efficiently.
- Report/communicate the outcome of investigations to DHH

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and/or other appropriate agencies or entities for further investigation and/or prosecution, as applicable.

- Trend suspected fraudulent or abusive activity in order to identify areas of concern and/or opportunities for improvement.

The QMC is chaired by Barbara Freeman, M.D., President and Chief Medical Officer. Additional committee members include senior staff member representatives from all areas of the organization. The QMC meets at least on a quarterly basis to:

- Review current CHS policies and state-specific policies.
- Develop or revise policies and procedures, as needed.
- Analyze data related to potential abusive or fraudulent situations.
- Investigate potential abusive or fraudulent situations.
- Report findings.
- Evaluate the overall Compliance Plan.

Additional staff with specific expertise may participate, on an ad-hoc basis, to assist the QMC in establishing structures for specific compliance detection, prevention and mitigation processes.

The policies, procedures, tools and reports established by the QMC are implemented on a daily basis by the Quality Management Department. The QMC may refer issues of a clinical nature, or potential quality of care concerns, to CHS-LA's Peer Review Committee (PRC) or to appropriate investigative authorities, based upon severity.

In an effort to ensure that CHS-LA does not enter into a relationship with a person who is debarred, suspended or excluded from participating in procurement activities under federal acquisition legislation or from participating in procurement activities under regulations issued under Executive Order No. 12549, and to ensure compliance with applicable provisions of 42 CFR Part 376 (2009, as amended), CHS-LA will screen any and all potential employees and contracted providers/entities prior to employment and on a monthly basis thereafter by searching the websites of the Office of Inspector General's List of Excluded Individuals/Entities, Health Care Integrity and Protection Data Bank and Excluded Parties List Serve. Any and all parties that are identified as being included in any of these lists will be reported to the Compliance Officer and to DHH within one (1) business day of identification.

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Section P: **Claims Management (Section 14 of RFP)**

Requirement P.1: *Describe the capabilities of your claims management systems as it relates to each of the requirements as specified in Electronic Claims Management Functionality Section and the Adherence to Key Claims Management Standards Section. In your response explain whether and how your systems meet (or exceed) each of these requirements. Cite at least three examples from similar contracts.*

Response: [NOTE: This question was answered in accordance with CCN-P and not CCN-S. CCN-S did not contain the Key Claims Management Standards.]

Community Health Solutions of Louisiana (CHS-LA) will comply with DHH’s Electronic Claims Data Interchange and obtain annual certification of electronically submitted claims.

CHS-LA will subcontract with an experienced independent firm, contingent upon approval by DHH, to conduct Electronic Data Processing (EDP) and compliance audits in accordance with applicable federal and state auditing standards for applications comparable with the scope of the Contract’s System application. The independent audit firm will:

- Perform limited scope EDP audits on an ongoing annual basis. The audits will be based on DHH’s audit program specifications. Audits will be performed at:
 - The conclusion of the first twelve (12) month period.
 - Each twelve (12) month period thereafter while the contract is in force.
- Perform a comprehensive audit annually to validate CHS-LA’s compliance with the obligations specified in the RFP.

CHS-LA will pre-process claims and submit to Fiscal Intermediary (FI) clean claims for payment on a fee-for-service basis. All providers participating in the network will be educated on CHS-LA’s timely filing standards along with compliance with all applicable state and federal laws, rules and regulations.

CHS-LA will maintain an electronic claims management system that will:

- Capture attending and billing providers for each service provide to CHS-LA’s members.

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- Track all date iterations of the claim including, but not limited to:
 - Date received.
 - Date pre-processed.
 - Date submitted to FI.
 - Date additional information requested.
 - Date received back from FI.
- Capture in real-time all information regarding the claims including but not limited to:
 - Accurate history with dates of pre-processing results and adjudication results received from the FI.
 - Results of each claim such as:
 - Pre-processed results.
 - Payment results from FI.
 - Denied results from FI.
 - Results of appeal.

CHS-LA system will, upon receipt of payment information from FI, capture:

- Paid date.
- Check number.
- EFT number.

In an effort to provide FI with accurate and complete encounter data, CHS-LA's pre-processing requirements include, but are not limited to:

- Date.
- ICD-9 CM Vol. 1 and 2.
- ICD-9 Procedures Vol. 3.
- CPT/HCPCS.
- CPT/HCPCS Modifiers.
- CPT II/HCPCS Level II.
- Place of Service.
- Units of Service.

CHS-LA will update codes based on HIPAA standards. Codes updated include, but are not limited to:

- ICD-9.
- CPT.
- HCPCS.

CHS-LA will accept all claims for service provided to members enrolled in the program. Claims submissions from providers can be electronic or non-electronic.

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CHS-LA ensures that our electronic claims management (ECM) system complies with the information exchange and data management requirements exchanges as specified in the RFP.

CHS-LA's ECM system provides online capability to obtain pre-processing status information.

CHS-LA system tracks EFT information received from the FI.

CHS-LA will adhere to the requirement identified in CCN-P Section 17.1.8 (claims management).

CHS-LA requires that all contracted providers comply, at all times, with standardized billing forms and formats, and all future updates for Professional claims, (CMS 1500) and Institutional claims (UB 04).

CHS-LA's ECM system can be configured to comply with the requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010.

CHS-LA's ECM system can be reconfigured, within ninety (90) calendar days of notice by DHH, to accommodate any changes in claims billing and pre-processing that are requested by DHH.

CHS-LA's ECM system will have DHH approved procedures available to providers in written and online form for the acceptance of claim submissions which include processes for:

- Date of actual receipt of non-electronic claims.
- Date and time of electronic claims.
- Reviewing claims for accuracy and acceptability.
- Securing receipt of all claims for pre-processing.
- Determining that claims are acceptable as clean claims.

CHS-LA's ECM system will have DHH approved procedures for notifying providers in written and online form of batch rejections. This information will contain:

- Date batch was received by CHS-LA.
- Date of rejection.
- CHS-LA name and identification.
- Batch submitter's name or identification number.
- Reason batch is rejected.

CHS-LA assumes all costs associated with claims pre-processing, including costs as a result of pre-processing errors caused by CHS-LA.

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CHS-LA's ECM system will provide online notification to contracted providers to file claims associated with covered services directly to us.

CHS-LA system edits include, but are not limited to:

- Claim is matched to member using member Medicaid ID. If no member is found, claim is rejected and HIPAA 277 Claims Status is sent for electronic claims and letter sent for paper claims.
- Billing/Pay to provider is linked to claim using the previously loaded provider file. If no match is found, claim is sent to workflow for review.
- Servicing provider is linked to claim using the previously loaded provider file. If no match is found, claim is sent to workflow for review.
- Timely filing validation - If the claim is not received within the state specified time frame, the claim is denied.
- Duplicate claim validation - If claim is an exact duplicate of a paid claim, the system will deny the claim. If claim is deemed a possible duplicate, the claim is sent to workflow for review.
- Claims edit validation - Verifies bill coding using Ingenix Claims Edit guidelines.
 - Invalid, deleted or unlisted CPT/HCPCS code - Claim is denied.
 - CPT/HCPCS code has a bilateral indicator - System will verify there is a valid bilateral modifier. If no valid modifier, the claim is sent to workflow for review.
 - CPT/HCPCS code has a digit indicator - System will verify there is a valid digit modifier. If no valid modifier, the claim is sent to workflow for review.
 - Anesthesia CPT/HCPCS code not performed by CRNA or anesthesiologist - Claim is denied.
 - Surgery CPT/HCPCS code with ANES modifier - Claim is flagged for review or original line denied and new line created with appropriate Anesthesia code. This is determined by client setting.
 - Multiple anesthesia procedures - Only primary anesthesia code is allowed, all additional anesthesia procedures are denied.
 - Claim is analyzed for bundling or unbundling of charges - Claim is recoded per claims edit criteria or claim is sent to workflow for review. This is determined by client setting
 - Claim is analyzed for multiple surgical procedures:
 - Reduction - Payment calculation will be reduced based on client setting.
 - CPT/HCPCS is analyzed for valid place of service - If invalid, charge will be denied.

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- CPT/HCPCS is analyzed for valid modifier 26 usage - If invalid, charge will be denied.
- CPT/HCPCS is analyzed for appropriate gender - If invalid, charge will be denied.
- CPT/HCPCS is analyzed for appropriate age - If invalid, charge will be denied.
- CPT/HCPCS is analyzed for appropriate frequency per day - If invalid, charge will be denied.
- CPT/HCPCS is analyzed for follow-up days within a global surgical package - If invalid, charge will be denied.
- Modifier validation - If modifier is not appropriate for procedure code, the claim is sent to workflow for review.
- Invalid, deleted or unlisted ICD-9 code - Claim is denied.
- ICD-9 validation - If ICD-9 is not appropriate for procedure code, the claim is sent to workflow for review.
- ICD-9 is analyzed for appropriate gender - If invalid, the charge will be denied.
- ICD-9 is analyzed for appropriate age - If invalid, the charge will be denied.
- Referral number validation - If service/provider requires a referral number, the system will match the referrals received for the member using the date of service and servicing provider NPI. If no referral found, the claim is sent to workflow for review.
- Precertification validation - If service requires precertification, the system will match precertifications received for the member using the service type and the dates of service. If no precertification is found, the claim is sent to workflow for review.
- Form validation - If service requires a specific State form, the system will verify that a form attachment has been received with the claim. If form is received, the claim is sent to workflow for review. If no form is received, the claim is denied.
- State specified billing requirements validation - The system will verify all State specified billing requirements have been met for the service rendered. If not met, the claim is denied.
- Visit limit validation - The system will verify that any applicable visit limit has not been met using the member visit accumulators. If met, the claim is denied. If not met, the visit accumulator is updated.
- Fee Schedule applied to claim - The program required fee schedule will be applied to claim.

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CHS-LA has qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, who review post-payment claims samples to ensure services provided were medically necessary.

In the event a non-clean claim is received by CHS-LA from a provider, we will notify the provider of the additional information that is needed in order to complete the pre-processing.

CHS-LA will monitor prompt claims payment upon receipt of claim payment data from the FI.

CHS-LA will maintain a complaint log that will capture and track any complaints received by members and the resolution thereof.

CHS-LA system ensures that ninety-nine per cent (99%) of all clean claims that are received will be forwarded to the FI within two (2) business days. Notification will be sent to the provider in the event a non-clean claim is submitted informing of the necessary information/documentation required in order to complete pre-processing of the claim.

CHS-LA's ECM system has a validation capability to ensure a provider has not been excluded from participation in Medicare, Medicaid, or CHIP program pursuant to Section 1128 or 1156 of the Social Security Act or is otherwise not in good standing with DHH.

CHS-LA's ECM will have an internal claims dispute procedure in place for DHH review and approval for pre-processed claims. Our system will track and monitor the status and resolution of all claims pre-processing disputes.

CHS-LA will submit monthly claims pre-processing accuracy percentage reports to DHH. This report captures the audit results based on a randomly selected sample consisting of a pre-determined percentage of pre-processed claims. Audits are performed by CHS-LA's Continuous Quality Improvement (CQI) staff.

Each claim selected will include:

- Claim data correctly entered into the claims pre-processing system.
 - Claim is associated with the correct provider.
 - Proper authorization was obtained for the service.
 - Member eligibility at pre-processing date correctly applied.
 - Duplicate pre-processing of the same claim has not occurred.
-

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- Denial reason appropriately applied.
- Modifier codes correctly applied and proper coding.

The result of testing will be documented to include:

- Results for each attribute tested for each pre-processed claim selected.
- Explanation of each pre-processing error.
- Determination if the error is the result of a keying error or the result of an error in the configuration or table maintenance of the claims pre-processing system.
- Claims pre-processed in error have been corrected.

CHS-LA has the ability to move to future code sets as required.

Our system captures HCPCS Level II and Category II CPT codes to assist in the evaluation of performance measures. Our system also has the capability to convert paper claims to electronic encounter data for submission in the appropriate HIPAA compliant formats to FI.

Our system is configured to recognize and identify exception codes for the purpose of repairing denied encounters.

CHS-LA reports encounter data to the FI for the pre-processed claims. If pre-processed claims are rejected, once re-submitted, the encounter data shall be submitted to the FI.

CHS-LA system is configured to capture and validate the data elements that must be included in encounters as outlined in DHH provider billing manuals.

Our system has the capability to identify any issues that prevent processing of an encounter. The standards we will follow are that ninety per cent (90%) of reported repairable errors will be addressed within thirty (30) calendar days and ninety-nine per cent (99%) of reported repairable errors within sixty (60) calendar days or within a negotiated time frame approved by DHH.

CHS--LA will submit ninety-five per cent (95%) of its encounter data monthly due no later than the twenty-fifth (25th) calendar day of the month following the month in which they were pre-processed.

CHS-LA will be responsible for capturing all encounter data into a single file. The files will include pre-processed claims that have been adjusted as a result of resubmission.

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CHS-LA will adhere to all applicable federal and/or department payment rules in the definition and treatment of certain data elements, such as units of service that are a standard file in the encounter data submissions.

CHS-LA will submit quarterly Claims Summary Reports for pre-processed claims to DHH by GSA and by claim type.

Recent examples of similar contracts are:

The Florida Healthy Kids Program-(SCHIP) - Our Services included:

- Provider Network.
- Care Management.
- Claims Processing and Adjudication.
- Member/Provider Customer Service.
- Program Management.
- Reporting.

The Texas Healthy Kids Program-(SCHIP)- Our Services included:

- Provider Network.
- Care Management.
- Claims Processing and Adjudication.
- Member/Provider Customer Service.
- Program Management and Reporting.

The Florida Comprehensive Health Association(FCHA) - High Risk Pool - Our services included:

- Care Management,
- Member/Provider Customer Services and
- Claims Processing and Adjudication.

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Section P: **Claims Management (Section 14 of RFP)**

Requirement P.2: *Describe your methodology for ensuring that claims payment accuracy standards will be achieved per, Adherence to Key Claims Management Standards Section. At a minimum address the following in your response:*

1. *The process for auditing a sample of claims as described in Key Claims Management Standards Section;*
1. *The sampling methodology itself;*
2. *Documentation of the results of these audits; and*
3. *The processes for implementing any necessary corrective actions resulting from an audit.*

Response: [NOTE: This question was answered in accordance with CCN-P and not CCN-S. CCN-S did not contain the Key Claims Management Standards.]

To ensure claims payment accuracy standards will be achieved, Community Health Solutions of Louisiana (CHS-LA) will use an automated Management Information System (MIS) which accepts provider claims, verifies eligibility, validates prior authorization, pre-processes and submits data to DHH’s Fiscal Intermediary (FI). All such data will comply with all applicable federal and state reporting requirements, including Medicaid confidentiality, HIPAA and American Recovery and Reinvestment Act privacy and security requirements.

Training and educational initiatives are in place to educate, inform and notify all providers and personnel involved in the program of the compliance requirements:

- Through the dissemination of educational materials, (i.e. Provider Manuals) as well as on-site training, all contracted providers will be informed and notified of all data, standardized forms and filing requirements for claim processing and for submitting clean claims directly to CHS-LA for pre-processing. Records of all educational materials and trainings shall be maintained for documentation purposes.
- CHS -LA personnel will receive appropriate initial and ongoing education, orientation and training sessions to fulfill the requirements of their positions. All such training will include, but not be limited to, an overview of DHH’s Policy and

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Procedures Manuals, Contracts and State and Federal requirements specific to individual job functions.

The MIS facilitates the process for auditing a sample of claims as described in the Key Claims Management Standards Section. Our system is configured to randomly select a pre-determined percentage of pre-processed claims for daily audit and will produce daily audit reports for internal review prior to the pre-processed claims being sent to the FI for payment.

Each claim selected for audit will be tested for the following:

- Claim data was correctly entered into the claims pre-processing system.
- Claim is associated with the correct provider.
- Proper authorization was obtained for the service, if applicable.
- Member eligibility at pre-processing date was correctly applied.
- Duplicate pre-processing of the same claim has not occurred.
- Denial reason was appropriately applied.
- Modifier codes were correctly applied.

The sampling methodology for ensuring claims payment accuracy shall be based on system validation of compliance with the following Contract requirements:

- Ninety-nine per cent (99%) submission rate of clean claims received, forwarded and received by the FI within two (2) business days.
- Clean paper claims requiring attachments submitted within four (4) business days from receipt from the provider.
- Time and date stamp applied all clean claims when received by the provider, whether received in paper or in electronic 837 formats.
- Claims contain the Julian date of receipt and date of submission to the FI and the Internal Control Number (ICN) will reflect the Julian date the claims were pre-processed.
- Verification of member eligibility.
- Validation of prior authorization, if applicable.
- Verification of medical necessity.
- Documentation verifying that, in the event a claim was partially denied on the basis the provider did not submit required information, a remittance advice or electronic notice identifies all such information.

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- Verification the provider is:
 - Currently contracted.
 - Not excluded from providing services under Medicare, Medicaid, and/or SCHIP.
 - Compliant with NPI.
 - Compliant with standard paper billing forms and formats, and all future updates.

- CHS-LA will validate claims receipt date from provider is within timely filing guidelines.
- CHS-LA will confirm all claims contain all data elements, including:
 - Date.
 - ICD-9 CM Vol 1 and 2.
 - ICD-9 Procedures Vol 3.
 - CPT/HCPCS
 - CPT/HCPCS Modifiers
 - CPT II/HCPCS Level II
 - Place of Service
 - Units of Service

The audit process will verify that an internal appeals process, claims dispute procedure and complaint log are in place, and that a peer-to-peer internal review process is established separate from the parties who made the original determination to review disputed authorizations.

The result of testing will be documented to include:

- Results for each attribute tested for each pre-processed claim selected.
- Explanation of each pre-processing error.
- Determination if the error is the result of a keying error or the result of an error in the configuration or table maintenance of the claims pre-processing system.
- Claims pre-processed in error have been corrected.

Documentation of all audit results shall be available upon request and documented through the Management Information System, in HIPAA compliant formats, and shall contain detailed explanation of each audit category.

Based on the audit results, CHS-LA will immediately take corrective actions to correct any deficiencies that were identified during the audit process. This process includes any required system configurations,

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updates, revisions to provider manuals, online information, continued provider or staff education and/or training.

Upon written request, CHS-LA will provide to state auditors files for any specified accounting period that a valid contract exists in a file format or audit defined media, magnetic tapes, CD or other media compatible with DHH and/or state auditor's facilities.

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Section P: **Claims Management (Section 14 of RFP)**

Requirement P.3: *Describe your methodology for ensuring that the claims pre-processing, including adherence to all service authorization procedures, are met.*

Response: Community Health Solutions of Louisiana (CHS-LA) has developed defined processes to ensure that all requirements for claims pre-processing, including adherence to all service authorization procedures, are satisfied so that accurate and complete claims data is provided to the Fiscal Intermediary (FI) for all levels of health care services.

CHS-LA's Management Information System (MIS) facilitates the auditing of individual claims including the production of a simple random claim sample based on a pre-determined percent of claims received from providers for pre-processing. The audit sample is produced daily for internal audit prior to pre-processed claims being forwarded to FI for processing. Claims selected for audit are reviewed for adherence to Contract requirements and procedures including, but not limited to:

- Minimum of ninety-nine per cent (99%) submission rate of clean claims received are forwarded and received by the FI within two (2) business days.
- Minimum of ninety-nine per cent (99%) submission rate of clean paper claims requiring attachments are submitted to the FI within four (4) business days of receipt from the provider.
- Clean claims, including paper and electronic submissions, are time and date stamped to reflect Julian date of receipt and date of submission to FI.
- Internal Control Number (ICN) is assigned to each claim received and reflects the Julian date that the claim was pre-processed.
- Member eligibility is valid for date(s) of service.
- Provider information is accurate including, but not limited to:
 - Currently contracted.
 - Not excluded from providing services under Medicare, Medicaid, SCHIP program pursuant to Section 1128 or 1156 of the Social Security Act or is otherwise not in good standing with DHH.
 - Provider Taxonomy

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- Provider Specialty.
- Provider Sub-Specialty.
- National Provider Identifier (NPI) for rendering provider.
- Received Date is within timely filing guidelines (provided to providers).
- Claims are submitted on standardized paper billing forms and formats for Professional claims (CMS-1500), Institutional claims (UB04), and Louisiana's KM3 form for EPSDT/KidMed billing of paper claims; electronic claims are submitted in the standard HIPAA transaction formats.
- Claim contains all required data element in accordance with Contract and Billing Manuals including, but not limited to:
 - Date of Service.
 - ICD-9 CM Vol. 1 and 2.
 - Diagnosis Pointer.
 - CPT/HCPCS.
 - CPT/HCPCS Modifiers.
 - CPT II/HCPCS Level II submitted charge is entered as 0.00.
 - Place of Service (POS).
 - Required attachments.
- Compliance with National Correct Coding Initiative.

The methodology to ensure adherence to all service authorization procedures shall include validation of:

- Inpatient Service Authorizations:
 - Authorization Number
 - Provider of Service
 - Multiple Units of service
 - Length of Stay
 - Concurrent Review
 - Retrospective Review
 - Medical Necessity
 - Outpatient Service Authorizations:
 - Authorization Number
 - Provider of Service
 - Units of Service (if open ended, the maximum authorized units will be validated against number of units billed as well as previously billed units)
 - Specialist Referrals (Non-Par):
 - Authorization Number
 - Provider of Service
 - Units of Service (if open ended, the maximum authorized units will be validated against number of units billed as well as previously billed units)
-

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- Retrospective Approval
- Medical Necessity Review

CHS-LA maintains detailed audit reports clearly documenting all audit findings and audit scores.

Based on our findings, CHS-LA will immediately take corrective action to address any pre-processing deficiencies that were identified during the audit process. This process includes system configuration or updates; continued and enhanced provider education; and internal training.

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Section Q: **Information Systems (Section 13 of RFP)**

Requirement Q.1: *Describe your approach for implementing Management Information Systems in support of this RFP, including:*

- *Capability and capacity assessment to determine if new or upgraded systems, enhanced systems functionality and/or additional systems capacity are required to meet contract requirements;*
- *Configuration of systems (e.g., business rules, valid values for critical data, data exchanges/interfaces) to accommodate contract requirements;*
- *System setup for intake, processing and acceptance of one-time data feeds from the State and other sources, e.g., initial set of CCN enrollees, claims/service utilization history for the initial set of CCN enrollees, active/open service authorizations for the initial set CCN enrollees, etc.; and*
- *Internal and joint (CCN and DHH) testing of one-time and ongoing exchanges of eligibility/enrollment, provider network, claims/encounters and other data.*
- *Provide a Louisiana Medicaid CCN-Program-specific work plan that captures:*
 - *Key activities and timeframes and*
 - *Projected resource requirements from your organization for implementing information systems in support of this contract.*
 - *Describe your historical data process including but not limited to:*
 - *Number of years retained;*
 - *How the data is stored; and*
 - *How accessible it is.*

The work plan should cover activities from contract award to the start date of operations.

Response: Community Health Solutions of Louisiana’s (CHS-LA’s) approach for implementing Management Information Systems (MIS) in support of the RFP includes:

Capability and capacity assessment

CHS-LA’s capacity plan will outline the strategy for:

- Assessing overall solution and component performance.
 - Using the information to develop the plan for component acquisition, configuration and upgrade as warranted.
-

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Planning for capacity will ensure that the business requirements are efficiently and effectively met by the infrastructure and application elements of the solutions. This provides CHS-LA management with:

- A clear statement of the capabilities of all the resources and services required to fulfill obligations.
- An assessment of current capabilities.
- A list of resources and services to be upgraded or to be acquired.
- A projection of the resources and services capacities required to fulfill future obligations.

CHS-LA has recently upgraded hardware for its application systems. Currently we are utilizing only twenty-five per cent (25%) of the overall capacity available.

Configuration of systems

CHS-LA's approach for configuring all systems consists of the following:

- Management.
- Preparation and execution.
- Reporting (results).

Management

A Project Office will be established to facilitate communication and coordination among internal and external entities.

Preparation/Execution

Based on agreed upon business application and infrastructure requirements, a gap analysis will be completed to identify any detailed requirements that need attention. These tasks will require planning and development. The entire solution will be tested via test plan(s) and test cases.

Reporting (results)

Assessments of system testing results leading to readiness/go live.

Consensus Care Management (CCM)

The Consensus Care Management system is a data-driven, rules-based application. It was built from the ground up with the understanding that client requirements would vary and need to be implemented quickly and seamlessly. The following areas will be evaluated and will form the basis for detailed requirements gathering and subsequently gap analysis:

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- Assessments
 - Which of the current Health Risk Assessment (HRA) and Disease Specific Assessments (DSA) will be implemented? Will there be any age-based refinements required?
- Educations
 - Which of the current educations will be implemented? Consensus can very easily adopt new educations.
- Surveys
 - Which of the current surveys will be implemented? Consensus can add surveys on demand.
- Reports
 - Reports required by the RFP have been mapped to current data warehouse reports within CHS-LA, but, with some of the specified reports lacking details, further detailed requirements and gap analysis will be required.
- Operational Reports
 - Operational reports are ones that “live” in Consensus Care Management application and, as a snapshot in time, typically support items such as work load.
- Utilization Management
 - Consensus Care Management has specific workflow and out-of-network rules administration requirements and gap analysis.
- Security
 - Consensus Care Management is designed around function/action security meaning that all action is controlled at the lowest level. The function/actions can then be grouped into meaningful roles. DHH roles will have to be defined that meet DHH requirements but must also meet HIPAA guidelines.
- Codes and Dropdown lists
 - Consensus has thousands of codes for dropdown lists and client specified processing that can be tailored to meet DHH terminology. These will need to be reviewed and configured.
- Extract, Transform and Load(ETL)
 - ETL process will bring all file exchanges into and out of the Consensus Care Management common structure. Layouts not contained within the RFP will need to be reviewed and gap analysis will be performed.

The Claims pre-processing system is broken down into three areas:

- Enrollment/Claims Data System (ECD) - Used for claims pre-processing and Eligibility validation.
-

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- HEDI Parser (HPS) - Receives/validates HIPAA transaction code sets and returns 997 acknowledgement to Trading Partners.
- Provider Contracting System (PCRS) and Provider Credentialing System (PCS) - Maintains all provider information for CHS-LA contracted providers and other servicing providers.

Enrollment/Claims Data System

The Enrollment/Claims Data System used by CHS-LA is a rules-based, highly flexible system and is based on a user-defined rules engine. This provides CHS-LA with the ability to configure the system based on client specific requirements with little to no programmer intervention.

To configure the system for accepting, processing and transmitting data from/to DHH and the Fiscal Intermediary (FI), CHS-LA will create basic system records/functions such as:

- System Administrator Record.
- Main Client Record.
- Client Admin Record.
- Establish Sub-Group categories.
- Update system with state specific codes such as:
- Medicaid eligibility type.
- Disenrollment reasons.
- Claim type cross walk.
- Repairable denial codes.
- Build plan rules using provider manuals for claims pre-processing.
- Modify (if necessary) existing ETL processes to accommodate client specific requirements.

The system has built-in validation tools that do not require configuration. These validations include, but are not limited to:

- Date validation.
- Procedure code validation.
- Diagnosis code validation.
- Ingenix claims edit rule validation.
- Address validation based upon USPS guidelines.

HEDI Parser

There are four types of profiles used by the HEDI application which include:

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- Server profile.
- Client profile.
- Database profile.
- SMTP profile.

Server Profile

The HEDI server profile contains any global settings or flags needed for general HEDI operation and includes the configuration of the following items:

- Profile Name.
- Status (Active/Inactive).
- Logging Level.
- Activity Logging.
- Log File Location.
- Archive Location.
- Archive Frequency.
- ISA Identifier & Qualifier.
- ISA Control ID.
- Group Control.
- Activity Logging.
- ISA Version.

Client Profile

The client profile represents an agreement with an external trading partner. It contains their connection and verification info, as well as paths needed to move files through the server for processing. Configuration of the following items are required for each external trading partner:

- Client Profile ID
 - Status (Active/Inactive)
 - Type - Indicates who will be doing the transferring when files need to be moved.
 - Remote - HEDI is the server. The Trading partner uses an FTP client, a web browser, etc. to upload files to their \Incoming path and download them from their \Outgoing.
 - Local - The Trading partner is running the server and HEDI connects to it using the means available to it. It downloads files into the partner's \Incoming path and uploads them from \Outgoing.
 - Trading Partner Name
 - Polling & Frequency
 - Arrival Hook Executable
-

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- Remote Address – This is the IP address or phone number to which the Server module should connect.
- LoginID & Password
- Protocol – Indicates how the files are to be transferred.
- 997 – Indicates whether or not Functional Acknowledgements should be sent to this partner.
- Error Notification
- Archive Frequency
- Local Incoming Path
- Local Outgoing Path
- Local Incoming Queue
- Local Outgoing Queue
- Remote Incoming Path
- Remote Outgoing Path
- Incoming Naming Convention
- Outgoing Naming Convention
- Local 997 Logs Path
- Local Data Logs Path
- Retry Attempts & Interval
- Last Interchange Control Number
- File ID & Password
- Data ID & Password

Database Profile

The database profile is used to determine the location used to receive the HIPAA files. Configuration includes the following:

- Profile name.
- Status (Active/Inactive).
- Target Database.
- Application ID.
- Arrival Hook Executable.
- HTCS Incoming Path.
- HTCS Outgoing Path.

SMTP Profiles

Email notifications are sent via an SMTP mail server. Administrators may use this dialog to configure a connection to an SMTP server to allow the use of notifications. Configuration includes the following:

- SMTP Server name.
 - Account User ID.
-

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- Account Password.
- Authentication Method.
- SMTP Port.

Provider Contracting System (PCRS) and Provider Credentialing System (PCS)

The provider subsystems have the capability of tracking numerous data fields for each provider to support the credentialing, re-credentialing and network development process.

The Provider Contracting System (PCRS) and the Provider Credentialing System (PCS) utilize shared data elements and files expediting system readiness.

To prepare the system for accepting, processing and transmitting provider data from DHH and to the enrollment broker, CHS-LA will complete items such as:

- Crosswalk client specific provider types with system internal provider types.
- Crosswalk client specific provider specialty with system internal provider specialties.
- Modify existing or create ETL processes to accommodate client specific requirements. Establish required fields based on contract requirements. Required fields include but are not limited to:
 - NPI Number.
 - Taxonomy Codes
 - Sub-specialty.
 - Capacity.
 - License information.
 - Languages spoken.
 - Office Hours.

The system has built-in validation tools that do not require configuration. These validations include but are not limited to:

- Duplicate NPI verification.
- Required field validation.
- Address structure validation.

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System setup for intake, processing and acceptance of one-time data feeds from the State and other sources

CHS-LA's systems were developed using the concept of data ownership by one system. The data is then consumed by other systems through data exchanges. This provides CHS-LA with the ability to update all systems using data import to a single destination.

Our process for working with one time data feeds are as follows:

- Establish secure data exchange method.
- File layouts and supporting test data will be reviewed by CHS-LA staff and, if necessary, communication with the entity of the data source would be initiated to answer any questions.
- After the initial system configuration, the receipt of file layouts and supporting test data, CHS-LA will:
 - Develop ETL processes.
 - Load and unit test within the development environment.
 - Develop Quality assurance (QA) test plans.
 - Migrate code from Development to QA.
 - Execute QA test plans and verify. This will ensure that migration process to production is verified. We would also include any User Acceptance testing and verification at this time.
 - Upon the completion of the above, the process is moved into production and run to load data into the Production systems.

Internal and joint (CHS-LA and DHH) testing of one-time and ongoing data exchanges.

All testing will be run through CHS-LA's Project Office. Communication and coordination between all parties will be coordinated through this entity. In addition, the proposed Readiness Review Board consisting of key stake holders from DHH and CHS-LA will ensure that all testing milestones are reached within the agreed upon time frames.

Initial CHS-LA's Enrollees edits and business rules.

HIPAA Parser

- HIPAA required transaction set validation - Verifies all required transactions sets.
-

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- HIPAA transactions set value validation – Verifies accepted transaction set values.
- 997 – Functional Acknowledgment sent.

Eligibility File Load from Parser into ECD System

- Duplicate SSN validation – Verifies SSN is not associated with a different Medicaid ID. If duplicate is found, an error report is generated.
- Duplicate Name/DOB validation – Import process does a first name, last name and DOB search and verifies Medicaid ID. If match is found with different Medicaid ID an error report is generated.
- Address validation – Verifies and corrects address abbreviations, punctuations and structure per United States Postal Service (USPS) standards.
- Medical Home validation – Verifies member is enrolled with an active contracted Medical Home. If invalid Medical Home, an error report is generated.

Historical claim service utilization edits and business rules.

- Claim is matched to member using member Medicaid ID. If no member is found, claim information is reported as a reject.
- Billing/Pay to provider is linked to claim using the previously loaded provider file data. If the claim can not be linked to a provider, it is sent for manual review.
- Servicing provider is linked to claim using the previously loaded provider file. If no match, claim is sent to workflow for review.

Initial enrollees active/open service authorizations edits and business rules.

- Match member with Medicaid ID
- Validate member with Name/DOB validation
- Verify patient eligibility
- Verify PCP eligibility
- Validate Service Authorization number format checking for duplicate authorization.

Please see the attached CCN-S program-specific work plan for key activities and timeframes.

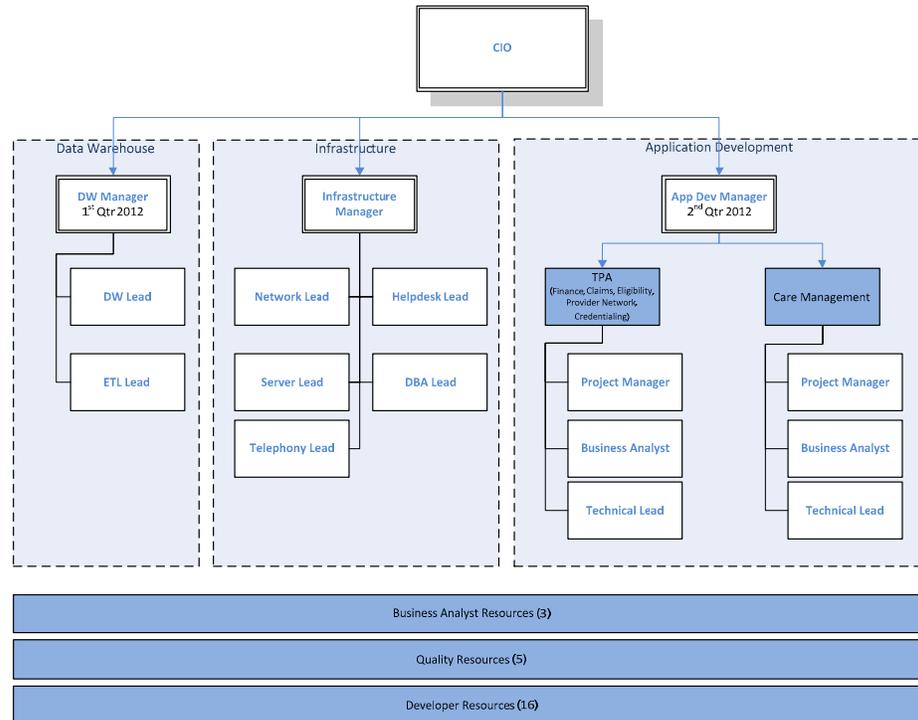
The following depicts CHS-LA's current and near term organizational chart. Any future resources are annotated with the expected timeframe

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for the requisition to be filled. In addition to the proposed resources, DHH should feel confident that CHS-LA will continually monitor resource allocations to ensure our mutual success.



CHS-LA will maintain historical data based on the following schedule:

- On-line for no less than six (6) years
- Archived for no less than ten (10) years

In addition, services that have a “once in a life time” indicator will remain as part of the active member’s history to be used for claims editing and will not be archived.

CHS-LA’s data is stored in the various software applications and consolidated in the data warehouse.

All data is stored on central servers within mostly SQL Server and located in a SAS70/SSAE16 Type II datacenter.

Fundamentally, operation data is not updated outside the operation systems. In the event this is required, a data patch is created and taken through the development process (DEV, QA/UAT, Production). Ad-hoc or Reporting data can be accessed through SQL Server Management Studios from within the data warehouse. Security is directly related to an Active Directory and re-credentialed annually.

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Physical access to the data center is limited to the greatest degree possible. Each employee must use a keycard + PIN code, as well as pass a fingerprint scan, to enter the main facility. Inside the data center each rack is locked with a unique combination lock.

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Section Q: **Information Systems (Section 13 of RFP)**

Requirement Q.1: *Describe your approach for implementing Management Information Systems in support of this RFP, including:*

- *Capability and capacity assessment to determine if new or upgraded systems, enhanced systems functionality and/or additional systems capacity are required to meet contract requirements;*
- *Configuration of systems (e.g., business rules, valid values for critical data, data exchanges/interfaces) to accommodate contract requirements;*
- *System setup for intake, processing and acceptance of one-time data feeds from the State and other sources, e.g., initial set of CCN enrollees, claims/service utilization history for the initial set of CCN enrollees, active/open service authorizations for the initial set CCN enrollees, etc.; and*
- *Internal and joint (CCN and DHH) testing of one-time and ongoing exchanges of eligibility/enrollment, provider network, claims/encounters and other data.*
- *Provide a Louisiana Medicaid CCN-Program-specific work plan that captures:*
 - *Key activities and timeframes and*
 - *Projected resource requirements from your organization for implementing information systems in support of this contract.*
 - *Describe your historical data process including but not limited to:*
 - *Number of years retained;*
 - *How the data is stored; and*
 - *How accessible it is.*

The work plan should cover activities from contract award to the start date of operations.

Attachment 1: MIS Implementation Workplan – Key Activities and Timeframes

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ID	Task Name	Resource Role	Estimated Effort	Estimated St Date	Estimated End Date	Predecessors
1	LA Medicaid Implementation		10265	Tue 7/5/11	Fri 10/28/11	
2	Project Initiation		120	Tue 7/5/11	Fri 7/22/11	
3	Charter	ImpMgr,ImpTeam	80	Tue 7/5/11	Fri 7/22/11	11FF
4	Refine and Communicate	ImpMgr,ImpTeam	8	Tue 7/5/11	Fri 7/22/11	
5	Project office Strategy		0			
6	Issue Tracking/Risk Management Strategy		0			
7	Communication Strategy		0			
8	Documentation Strategy		0			
9	Training Strategy		0			
10	Testing Strategy		0			
11	Organize Project Steering Committee	ImpMgr	8	Tue 7/5/11	Fri 7/22/11	
12	Develop Process/Roles \Stakeholder matrix	ImpMgr	8	Mon 7/18/11	Fri 7/22/11	
13	Define acceptance criteria	ImpMgr	16	Mon 7/18/11	Fri 7/22/11	
14	Execution Application		9732	Tue 7/5/11	Fri 9/23/11	
15	Requirements Gathering		1092	Tue 7/5/11	Fri 7/29/11	2SS
16	Consensus	ConsensusTeam,ETLTeam	292	Tue 7/5/11	Fri 7/22/11	
17	Assessment List		80			
18	Education List		10			
19	Survey List		10			
20	Operation Report List		2			
21	Security		40			
22	Role (Function/Action)		0			
23	Queue Roles(Reassign Into/Reassign From/View/Update)		0			
24	Codes		30			
25	Address Types		0			
26	Body Functional Systems (Cardiovascular, Circulatory, etc.)		0			
27	Contact Outcome Statuses		0			
28	Contact Reasons		0			
29	Contact Types (Phone, Mail, Fax, {in-out})		0			
30	Document Types		0			
31	Episode Reassignment Reasons		0			
32	Episode Types		0			
33	Family History Illness List		0			
34	Fulfillment Contact Statuses		0			
35	Immunization List		0			
36	Language Lists		0			
37	Medication Routes		0			
38	Network Types		0			
39	Note Types		0			
40	Phone Types		0			
41	Plan Types		0			
42	Provider License Statuses		0			
43	Provider License Types		0			
44	Quality Incident Categories and Types		0			
45	Referral Types (Physician, Facility)		0			
46	Responsible Party Relationships		0			
47	Service Types (Physician Types, Facility Types)		0			
48	Surgery Types		0			
49	Symptoms		0			
50	Task Types		0			
51	Time keeping activity types		0			
52	User Account Lock Reasons (for Security)		0			
53	User Roles List		0			
54	Various Age Limits		0			
55	Episode Queue Build Rules		80			
56	List of Queue		0			
57	Triggering ICD and CPT and rules		0			
58	ETL		40			
59	CPT		0			
60	CPT Modifiers		0			
61	ICD		0			
62	Diagnosis Class		0			
63	DrugTherapyClass		0			
64	Surgical Codes		0			
65	Immunizations		0			
66	NDC Codes		0			
67	Claims	ClaimTeam,ETLTeam	640	Tue 7/5/11	Fri 7/29/11	
68	Organization of Client Network Hierarchy		40			
69	Trading partners		40			
70	claim adjudication		340			
71	Fee Schedules		0			
72	Obtain Louisiana Provider Manuals for Configuration Summary		0			
73	Security (User/Roles/Function/Actions)		20			
74	ETL	ETLTeam	200			
75	Data Flow Diagrams/Interface Matrix		0			
76	Provider Network		0			
77	Providers		0			
78	Provider Specialty		0			
79	ProviderType		0			
80	Members		0			
81	Parrish		0			
82	Claims		0			
83	Place Of Service/Type of Bill		0			
84	DRG Codes		0			
85	Fund Codes		0			
86	Data Warehouse Reporting	DWHTeam	80	Tue 7/5/11	Fri 7/15/11	
87	Refine list of DWH reports		0			
88	CHS-LA Website	WebTeam	80	Tue 7/5/11	Fri 7/15/11	
89	Obtain website address for program		0			
90	Update existing websites as may be required i.e. state, CHS or other		0			
91	Determine links needed for program operations		0			
92	Obtain permission for links		0			

ID	Task Name	Resource Role	Estimated Effort	Estimated St Date	Estimated End Date	Predecessors
93	Confirm data to be placed on website		0			
94	GAP Analysis	ClaimTeam,ConsensusTeam,DWHTeam,ETLTeam	360	Mon 7/25/11	Fri 8/5/11	155S
95	Perform gap analysis		0			
96	Document findings of gap analysis		0			
97	Complete Functional Requirements per gap		0			
98	Operations Sign off - Functional Requirements Document		0			
99	Design/Construction	ClaimTeam,ConsensusTeam,DWHTeam,ETLTeam	3600	Mon 8/1/11	Fri 9/2/11	945S
100	Complete Claims Pre-processing Configuration Design Matrix		0			
101	Produce development specifications for gaps		0			
102	Testing	ClaimTeam,ConsensusTeam,DWHTeam,ETLTeam	4000	Fri 8/19/11	Fri 9/16/11	995S
103	Unit/System testing		0			
104	Adhoc Test		0			
105	User Acceptance Testing (UAT)		0			
106	Review UAT Plan		0			
107	UAT Test Plan Development		0			
108	Test Plans		0			
109	Develop Test Cases		0			
110	Review Test Cases		0			
111	Conduct User Acceptance Testing		0			
112	Interface/UAT testing		0			
113	Interface Testing		0			
114	EDI Certification		0			
115	Trading Partner testing		0			
116	Claims Pre-processing configuration testing		0			
117	Consensus Care Management		0			
118	Performance		0			
119	Training Environment	ClaimTeam,ConsensusTeam,DWHTeam,ETLTeam	160	Fri 9/2/11	Fri 9/16/11	
120	Parrallel/Model office		0	Fri 9/2/11	Fri 9/16/11	
121	Create Model Office environment		0	Fri 9/2/11	Fri 9/2/11	
122	Create 2 Model Office Usrid		0			
123	2 PC Dual Monitor, Printer		0			
124	Schedule Model Office time		0			
125	Internal end user training		0			
126	Plan Training		0			
127	Develop Training		0			
128	Conduct Training		0			
129	External user training		0			
130	Plan Training		0			
131	Develop Training		0			
132	Conduct Training		0			
133	Operations Sign off- Training		0			
134	Documentation	ClaimTeam,ConsensusTeam,DWHTeam,ETLTeam	120	Mon 8/1/11	Fri 9/2/11	
135	Update system documentation		0			
136	Release Notes		0			
137	Production Implementation	ClaimTeam,ConsensusTeam,DWHTeam,ETLTeam	400	Mon 9/19/11	Fri 9/23/11	
138	Develop deployment work plan		0			
139	Execute deployment work plan		0			
140	Verify configuration in Production Environment		0			
141	Production Acceptance		0			
142	Production		0			
143	Execution Infrastructure	InfrastructureTeam	293	Tue 7/5/11	Fri 9/16/11	
144	Datacenter		80			
145	Request larger net block from Peak10		0			
146	Order two 1U DirectAccess servers		0			
147	Setup DirectAccess for High Availability		0			
148	Transition from old Direct Access server to new HA servers		0			
149	Transition EdgeMarcs to new IPs/connection		0			
150	Disaster Recovery Execution Test		0			
151	Site		71			
152	Site surveys		4			
157	Research cabling vendor as needed		1			
158	Research ISPs (TWTC Metro preferred)		4			
159	Installation of equipment as needed		54			
160	Site documentation		8			
161	Networking		42			
162	Develop overall network scheme		16			
163	Assign blocks to each LA site.		1			
164	Preconfigure equipment		16			
165	All Routers, firewalls, switches, and WAPs can be preconfigured in a lab environment		0			
166	Shipment equipment to LA sites		1			
167	Update network documentation		8			
168	Equipment (Overall)		0			
169	FortiGate 60c Firewalls/ Edge servers as needed		0			
170	Cisco 2960 PoE Switches		0			
171	Cisco Aironet 3502 WAPs		0			
172	USB Keys for BitLocker		0			
173	Border servers as needed		0			
174	Backup Drives as needed		0			
175	Mixed length patch cables (Yellow and Black)		0			
176	UPS equipment as needed		0			
177	Licensing (Overall)		0			
178	LogMeIn Pro		0			
179	Windows 7 Enterprise		0			
180	Office 2010 Professional Plus		0			
181	UAG CAL		0			
182	ShadowProtect		0			
183	Telephony (IVR/ACD)		100			
184	Order new toll free (or local) point of contact phone numbers (or use existing CHS Louisiana toll free number, 888-982-4752)		0			
185	Configure call flow with IVR menu options		0			
186	Initial greeting(s)		0			
187	Open (Normal business hours)		0			

ID	Task Name	Resource Role	Estimated Effort	Estimated St Date	Estimated End Date	Predecessors
188	Closed (After hours – Nights/Weekends)		0			
189	Holidays		0			
190	Menus/prompts		0			
191	Open vs. closed options		0			
192	Care management, MPS, Spanish, auto-attendant, any other main branches		0			
193	Create campaign(s) to group ACD skills (for reporting purposes)		0			
194	Create ACD skills to be tied to menu options and route calls to agents		0			
195	Create teams for grouping agents (by department/management chain—for reporting purposes)		0			
196	Create agent accounts		0			
197	Assign skills to agents		0			
198	Order VOIP phone (DID) accounts		0			
199	Create station (phone) accounts within call center platform		0			
200	Equipment		0			
201	Order Cisco 7940 IP phones		0			
202	Order Headsets		0			
203	EdgeMarc VoIP (SIP) Appliance for the two additional offices located in Louisiana		0			
204	Installation & Testing		0			
205	Install EdgeMarc VoIP (SIP) Appliance		0			
206	Verify EdgeMarc appliance configuration and connectivity		0			
207	Connect phones to network infrastructure and install headsets		0			
208	Configure phones for DID numbers		0			
209	Verify phone connectivity		0			
210	Conduct test calling to verify DID numbers are working correctly		0			
211	Install call agent software on Call Center workstations		0			
212	Verify call agent software and phone connectivity with Call Center platform		0			
213	Results\Project Closure	ImpMgr	120	Mon 10/3/11	Fri 10/28/11	
214	Project Sign-off		0			
215	Administrative Closure		40			
216	Lessons Learned		60			
217	Close or Transition open Issues/Change Requests to maintenance team		20			

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Section Q: **Information Systems (Section 13 of RFP)**

Requirement Q.2: *Describe the ability within your systems to meet (or exceed) each of the requirements in Section 16 of the RFP and the CCN-P Systems Companion Guide. Address each requirement. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.*

Response: **[NOTE: With reference to the requirement description above: this response is per review of Section 16 of the Request for Proposals (RFP) and the CCN-S Systems Companion Guide (not the CCN-P Systems Companion Guide).]**

16.1 Community Health Solutions of Louisiana (CHS-LA) will comply with all reporting requirements established by DHH.

In addition to the existing standard reports and files (claims history, member eligibility reports, etc.), CHS-LA customizes reports to individual client specifications as agreed upon in the contract.

16.2 CHS-LA will coordinate with DHH to establish connection to DHH's FI using the established processes. CHS-LA will provide sample reports within forty-five (45) calendar days of contract execution in compliance with the RFP and the CCN-S Systems Companion Guide.

16.3 CHS-LA's reporting solutions are delivered through the Microsoft Suite of products; specifically Sql Server Reporting Services (SSRS) and Sql Server Integration Services (SSIS). Our staff of "on demand" report writers ensure accurate and timely delivery of reports and electronic files, including ad hoc reports.

Reports generated from within the transactional system are operational reports identifying point in time conditions for managerial review and intervention, if needed. Additionally, the data warehouse provides information over time (daily, weekly, monthly, and on demand) including tracking and trending capability.

CHS-LA will develop specific reporting once the state has identified its requirements and the contract has been awarded. These reports will be

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developed from our current reports and augmented for state specific requirements.

CHS-LA is able to create reports based upon the requirements and file layouts listed in the RFP and the CCN-S Systems Companion Guide.

16.4 Reporting is available in a wide variety of time frames and can be generated in the layout agreed upon. In the event that no data is applicable to a given report, a report shell can be generated conveying that information.

16.5 CHS-LA can certify the completeness and accuracy of the data being reported as per the RFP. This is based upon DHH's identification of the specific data that requires certification.

16.6 Ad Hoc Reports

CHS-LA's team of "on demand" report writers ensure accurate and timely delivery of reports and electronic files, including ad hoc reports. CHS-LA has the ability to provide ad hoc reports sixty (60) calendar days from the time of the request and completion of the specifications for the report(s) or other agreed upon timeframe.

16.7 CCN-S' Network of Providers and Subcontractors

The Provider Directory/Network Provider and Subcontract Registry can be provided in both electronic and printed versions. The electronic file can be provided in the layout specified by the CCN-S Systems Companion Guide.

CHS-LA offers printed directories by practice as well as individual practitioner listed by area serviced (county, parish, etc.).

CHS-LA can supply advance copies of the printed directory and electronic data files in the required layout as required by the CCN-S Systems Companion Guide. However, as contracting is an ongoing process and participating providers will be periodically added, any printed versions and/or advanced copies of electronic versions of the Provider Network directory may not include the most recent activity.

CHS-LA's current directory layout for printed participating providers includes the status of the provider in accepting new patients, the age ranges accepted by the office as well as languages spoken.

Provider's Medicaid ID number, tax identification number and NPI number are not included in any printed provider directories. All identification numbers for members and providers are protected by

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security measures for the systems network as well as each database within the network. Security includes multiple tiers set by user on a need to know basis. All transmissions to business partners are secure to ensure protection of this information. Information is only exchanged with appropriate business partners in accordance with HIPAA requirements

16.8 Ownership Disclosure

CHS-LA's current form CMS 1513 is included in this response per RFP requirements. CHS-LA will resubmit an updated form CMS 1513 prior to implementation of each contract period (annually by October 1st) and within thirty calendar days prior to the effective date of any change in CHS-LA's management, ownership or control according to the requirements set forth in the RFP.

16.9 Information Related to Business Transactions

CHS-LA will submit to DHH, or to the U.S. Department of Health & Human Services, within thirty-five (35) days of any request by DHH the following information:

- The ownership of any contractor with whom CHS-LA has had a business transaction totaling more than \$25,000 during the 12-month period immediately preceding the date of the request.
- Any business transaction between CHS-LA and a wholly owned supplier, or CHS-LA and any contractor, during the five-year period immediately preceding the date of the request that either exceed \$25,000 or five per cent (5%) of CHS-LA total operating expenses for any state fiscal year, whichever is greater

16.10 Information on Persons Convicted of Crimes

CHS-LA's system capabilities include the ability to terminate providers for cause with appropriate flags on the provider's record to ensure compliance with requirements in the RFP. CHS-LA will report all information regarding any provider convicted of a criminal offense under a program related to Medicare (Title XVIII) and Medicaid (Title XIX) and CHIP (Title XXI) as set forth in 42 CFR § 455.106 as stated in the RFP.

16.11 Errors

If an error in reporting occurs, corrected reports will be issued within fifteen (15) calendar days (or the first business day following 15 calendar days if the deadline occurs on a weekend or holiday) from the

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date of discovery, if possible. In the event corrected reports will not be available in that time period, notification will be sent to the recipient with the plan of action to correct the reports and an estimated time frame in which the corrected reports should be completed.

Dedicated in-house programmers ensure that CHS-LA can make changes in programming based upon specifications or need for correction in a timely fashion.

16.12 Report Submission Timeframes

CHS-LA currently produced reports at the following time increments based upon agreement with each client:

- Daily
- Weekly
- Monthly
- Quarterly
- Annually
- As requested / as needed

Customization of files and reports based upon the information in the RFP and the CCN-S Systems Companion Guide can be completed within sixty (60) days following agreement to produce reports and files.

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Section Q: **Information Systems (Section 13 of RFP)**

Requirement Q.3: *Describe in detail how your organization will ensure that the availability of its systems will, at a minimum, be equal to the standards set forth in the RFP. At a minimum your description should encompass: information and telecommunications systems architecture; business continuity/disaster recovery strategies; availability and/or recovery time objectives by major system; monitoring tools and resources; continuous testing of all applicable system functions, and periodic and ad-hoc testing of your business continuity/disaster recovery plan.*

Identify the timing of implementation of the mix of technologies and management strategies (policies and procedures) described in your response to (a), or indicate whether these technologies and management strategies are already in place.

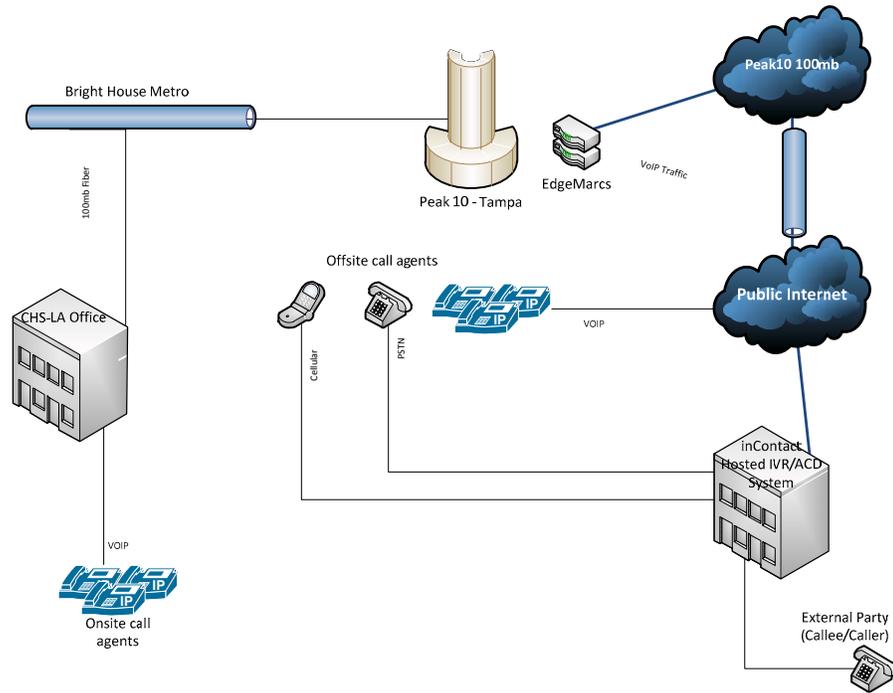
Elaborate, if applicable, on how you have successfully implemented the aforementioned mix of technologies and management strategies with other clients.

Response: Community Health Solutions of Louisiana (CHS-LA) will ensure availability of all aspects of our information systems and compliance with Request for Proposal (RFP) standards requirements.

Telephone-based IVR
DHH Requirements: 24/7
CHS-LA: 24/7

The infrastructure of our call center phone system has both system redundancy within the application as well as geographical redundancy with data centers in Salt Lake City, Utah, Los Angeles, California and Dallas, Texas, sufficient to provide twenty-four (24) hours a day, seven (7) days a week IVR availability.

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Data Center

DHH Requirements: 24/7

CHS-LA: 24/7

Our datacenter facility Peak Ten is a SAS70/SSAE16 Type II data center with personnel available 24/7. In addition, we have redundant internet connections from multiple providers. In the event that one provider drops, the internet traffic is automatically transitioned to a secondary provider.

Information Systems

DHH Requirements: 7a.m. - 7p.m. Central Time, Monday through Friday.

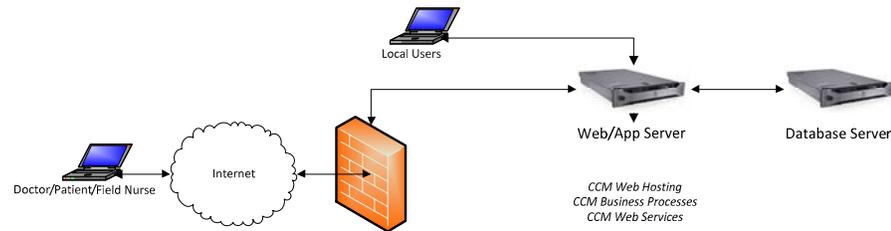
CHS-LA: 7a.m. - 7p.m. Central Time, Monday through Friday.

Our high-level application architecture encompasses a three tier Service Oriented Architecture (SOA) solution with all functionality and data stored on servers. This architecture enables easier backup and recovery.

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In the event of a Computer Installation and resident software being destroyed or damaged, CHS-LA will utilize back up hardware to apply the latest data backup. Transaction logs would then be applied to bring this system up to date and in line to where production was at failure. If backup hardware is unavailable, we have SLAs in place with Dell Incorporated.

A system interruption or failure resulting from network, operating hardware, software, or operations error that compromises the integrity of transaction data would be addressed by replacing applicable hardware or restoring from backup and/or depending on the severity of the issue within the application, the database would either be:

- Rolled back to a time prior to the event.
- Restored from backup and transaction logs applied.
- Data patch applied to correct data.

CHS-LA currently provides systems availability to users requiring 8a.m. – 7p.m. EST and will adjust this to DHH requirement to 7a.m. – 7p.m. Central Time, Monday through Friday.

CHS-LA's Contingency Plan specifies projected recovery times and data loss for mission-critical systems in the event of a declared disaster. Currently this plan calls for a range of recovery depending on the situation but can be estimated worst case from 24-36 hours.

CHS-LA will annually test the Contingency Plan through:

- Simulated disasters.
- Lower level failures.

The tests will be used to demonstrate to DHH that CHS-LA has the ability to restore system functions.

CHS-LA utilizes Peak10 for off-site storage and remote back-up of databases and servers. Our knowledge base maintains current procedures/standards, and system documentation. The data back-up policy and procedures describes the following backup frequencies:

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- Database: Nightly Differential, Weekly Full.
- Servers: Nightly Backup.

Note: We have the capacity to backup as frequent as every 15 minutes.

Monitoring tools and resources

CHS-LA currently uses Paessler's PRGT to monitor the network and LogMeIn Events to monitor hardware. Each production server is individually monitored at both a software and hardware level. Should operating parameters deviate from the norm (temperature, power loss, disk activity, CPU activity, etc.) alerts are automatically sent to the appropriate personnel and tracked via our Helpdesk system.

Change Management

CHS-LA's information systems change management and version control differs slightly between applications from infrastructure. Each is described below.

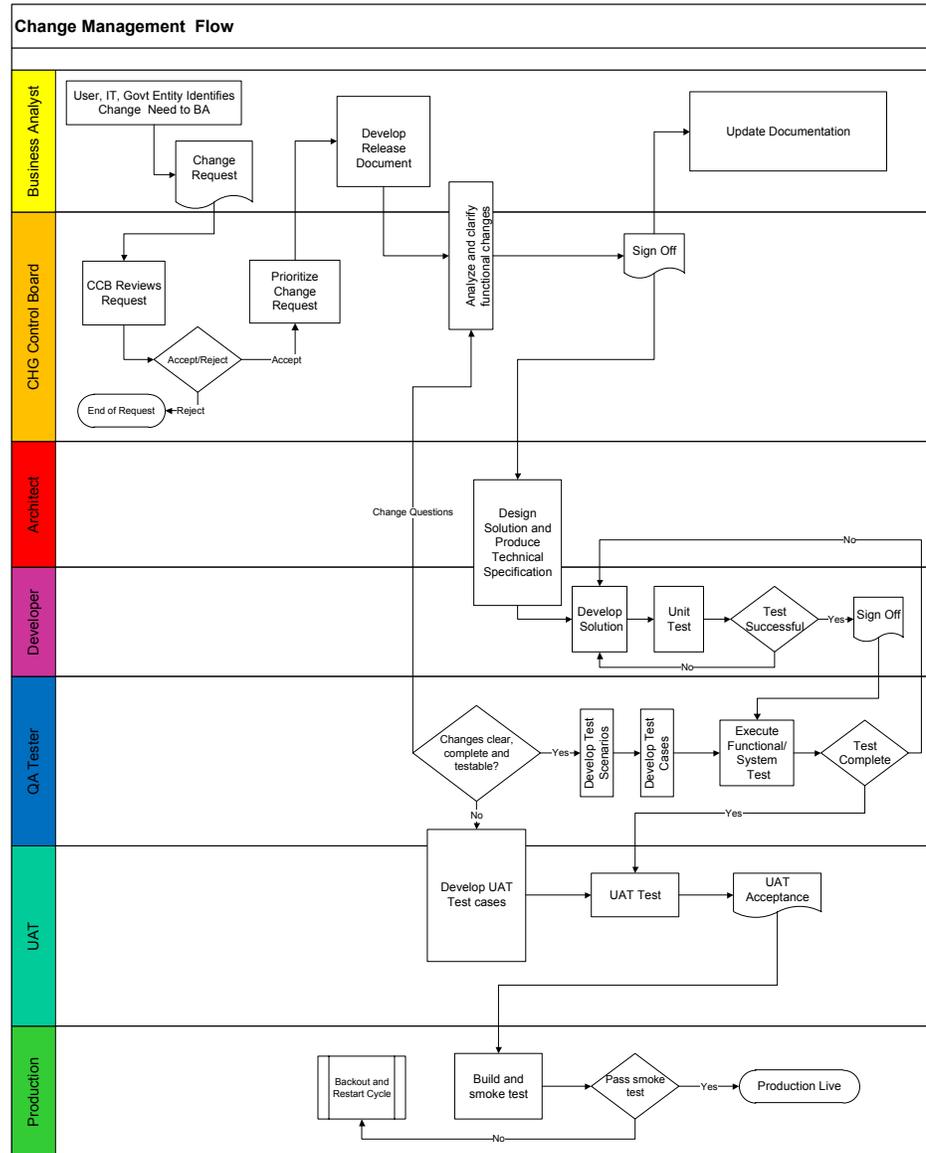
Application Change Management

Application Change Management is controlled by a process which includes all players in the application development lifecycle. Each release is assigned a number which is an indicator of the impact on the system. 1.2.3 Where 1 is a major release affecting database and major server and front end changes, 2 represents an application enhancement to functionality and 3 represent minor, fixes and modifications.

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Business Analyst (BA):

- BA receives the change from the user, IT or government entities and logs it for discussion with the Change Control Board.
- BA documents initial impact review.
- BA generates Release Document to identify all changes bundled in the release.
- BA provides further analysis and documents full impact of changes in the release.
- BA modifies user documentation prior to release.

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Change Control Board (CCB):

- CCB is made up of representatives from the business, and the IT teams.
- CCB reviews all requests and determines if the change needs to be made.
- If the change is rejected, it falls out of further processing and its status is set to Denied.
- If the change is accepted, it is prioritized with all other open change requests.
- CCB identifies the requests to be included in the release.

Architects

- Architects define the overall application architecture (i.e. security, database, interface, and communications).
- Architects resolve high-level functional issues.
- Architects coach the software engineering team in the development of the solution.
- Architects provide continuity in all major application solution decisions.

Development Team (DT)

- DT codes the application based on the functional specification.
- DT unit tests all application changes.

Quality Assurance Team (QA)

- QA reviews requirements to ensure all change requests are clearly defined and testable.
 - QA creates documentation that outlines the testing portion of the System Development Life Cycle.
 - QA develops test cases that meet the business and technical requirements that were developed from requirements gathering and system design. When applicable, test cases are re-used to test functionality when new code is introduced.
 - QA performs test execution by running each test case or set of conditions in the application itself. The result of the test is determined by comparing the actual results to the expected results.
 - Failure to meet expected functionality results in defect creation and management. The system does not move into production if there are Critical or High defects.
-

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- User Acceptance Test (UAT) test cases are designed to represent real business scenarios and functions relevant to the end-users (business users).
- UAT is the final step before business sign-off and implementation of the application into production. UAT helps find defects related to the usability of the application and ensures that the applications meet the functional requirements set forth in the business analysis phase.
- UAT Acceptance is an indication that the product is ready to be delivered to business satisfaction and expectations.

Visual Source Safe 2005

- Visual Source Safe is a standard Microsoft tool used for source code version control.

Production

- Once the build is in production a smoke test is performed. The smoke test is a non-invasive test that will ensure all system functions are running correctly (i.e. Phone Integration, Fax Integration, Database Connectivity, Installation, etc.).
- If the smoke test passes we are considered live in production and the results are communicated to the appropriate parties.
- If the smoke test fails, standard, pre-planned back-out procedures are implemented to roll production back to the way it was before the update. The results are communicated to the appropriate parties, and the development and test cycles are resumed to address the issue causing failure.

Infrastructure Change Management

CHS-LA uses a 3-tier approach to update and maintain the operating environment.

A. Development Server

1. Notify ALL stake holders of the pending updates and schedule.
 2. **Read and review** ALL notes on any Windows Updates/hotfixes.
 3. Segregate out any updates/hotfixes that do not need to be applied.
 4. Backup all development/database work on server.
 5. Apply ALL security updates first, reboot server.
 6. Apply ALL hotfixes and application specific updates and reboot if needed.
-

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7. Notify all stake holders that the updates/fixes have been applied.
 8. Over a 1 week period, test the system to see if there are any issues.
 9. Correct any issue(s), if any. Repeat testing of system. If complete failure, rollback.
 10. Move to QA if process completes without issue.
- B. QA Server
1. Notify ALL stake holders of the pending updates and schedule.
 2. **Read and review** ALL notes on any Windows Updates/hotfixes.
 3. Segregate out any updates/hotfixes that do not need to be applied.
 4. Backup all databases/Reports work on server.
 5. Apply ALL security updates first, reboot server.
 6. Apply ALL hotfixes and application specific updates and reboot if needed.
 7. Notify all stake holders that the updates/fixes have been applied.
 8. Over a 1 week period, test the system to see if there are any issues.
 9. Correct any issue(s), if any. Repeat testing of system. If complete failure, rollback.
 10. Move to Production if process completes without issue.
- C. Production Server
1. Notify ALL stake holders of the pending updates and schedule.
 2. **Read and review** ALL notes on any Windows Updates/hotfixes.
 3. Segregate out any updates/hotfixes that do not need to be applied.
 4. Backup all Production databases/FileStream folders on Server.
 5. Apply ALL security updates first, reboot server.
 6. Apply ALL hotfixes and application specific updates and reboot if needed.
 7. Notify all stake holders that the updates/fixes have been applied.
 8. Over a 1 week period, test the system to see if there are any issues.
 9. Correct any issue(s), if any. Repeat testing of system. [At this
-

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stage, ONLY if a major failure, then roll-back until a solution can be determined.]

Management strategies

Everything mentioned within this RFP response currently exists at CHS-LA. We do not see any major strategy differences from what is implemented for our current customers and would be customary within IS. For this program to be successful, it will be the detailed execution that becomes important. Our success will be assured by our experience in execution within our current and past clients specified below and the knowledge that went into developing our agile systems.

South Carolina (Medical Home Program)

South Carolina (Medically Complex Children's Waiver)

Texas (S-CHIP)

Florida (S-CHIP)

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Section Q: **Information Systems (Section 13 of RFP)**

Requirement Q.4: *Describe in detail:*

- *How your key production systems are designed to interoperate. In your response address all of the following:*
- *How identical or closely related data elements in different systems are named, formatted and maintained:*
 - *Are the data elements named consistently;*
 - *Are the data elements formatted similarly (# of characters, type-text, numeric, etc.);*
 - *Are the data elements updated/refreshed with the same frequency or in similar cycles; and*
 - *Are the data elements updated/refreshed in the same manner (manual input, data exchange, automated function, etc.).*
- *All exchanges of data between key production systems.*
 - *How each data exchange is triggered: a manually initiated process, an automated process, etc.*
 - *The frequency/periodicity of each data exchange: “real-time” (through a live point to-point interface or an interface “engine”), daily/nightly as triggered by a system processing job, biweekly, monthly, etc.*
- *As part of your response, provide diagrams that illustrate:*
 - *point-to-point interfaces,*
 - *information flows,*
 - *internal controls and*
 - *the networking arrangement (AKA “network diagram”) associated with the information systems profiled.*

These diagrams should provide insight into how your Systems will be organized and interact with DHH systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with the Louisiana Medicaid CCN Program.

Response:

Community Health Solutions of Louisiana (CHS-LA) appreciates that the inter-operation of key production systems is critical to the success of the program. Our solution has proven to provide the flexibility necessary to accommodate a wide range of client-specific needs.

Our custom solution provides the full availability and opportunity to maximize their consistency and how they inter-operate. Benefits of this

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development model are:

- Data elements are named consistently across applications.
- Data elements are formatted similarly.
- High efficiency is achieved by not duplicating functionality across systems.

Data elements are updated or refreshed in all systems following the same update frequency/schedule and performed by electronic transfer.

Based on our architecture, data is owned by one system and consumed by other systems through data exchanges.

Data exchanged between systems include but is not limited to:

- Eligibility data.
- Claims data.
- Provider data.
- Service authorization.
- Referral number.
- Financial data.

Data exchange methods include:

- Scheduled automated electronic transfer.
- Data sharing through the Data Warehouse.

Internal controls (checks and edits) are routinely performed to maintain data quality and ensure overall program integrity. Internal controls include but are not limited to:

- Required field validation.
- Length of field validation.
- Consistency validation.
- Data type validation.
- Field value validation.
- Transaction level Syntax edits (HIPAA Transaction Code Set validation).

Eligibility Exchange

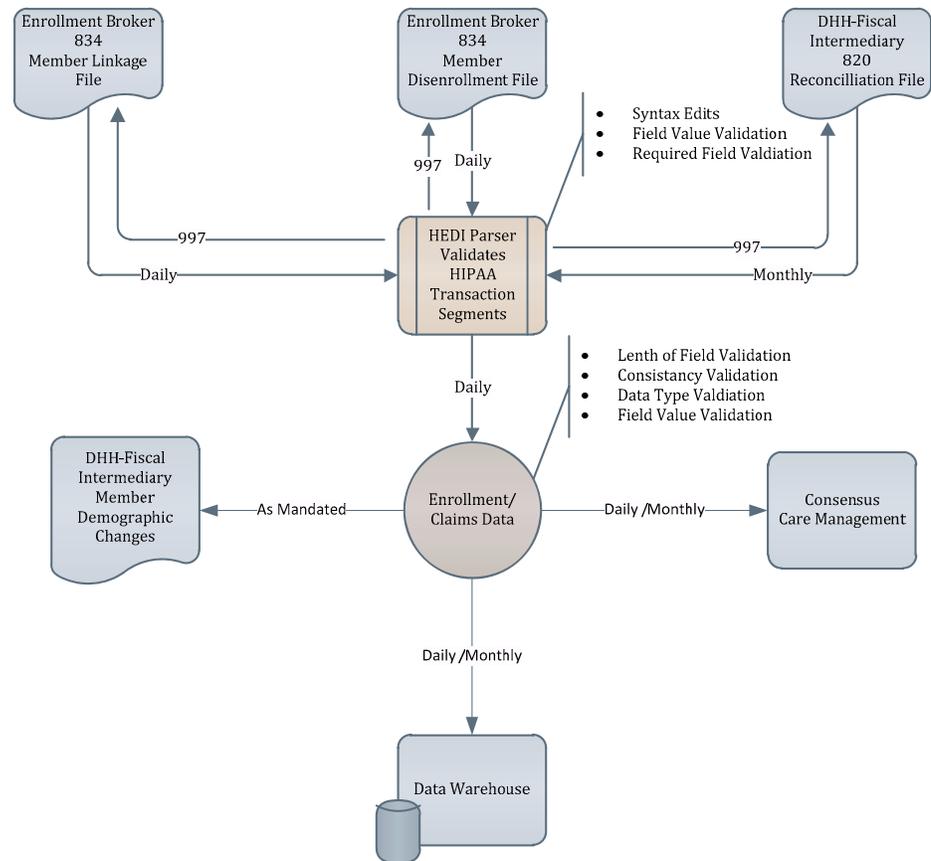
Responsible Party	Receiving Party	File/Report Name	Frequency
Enrollment Broker	CHS-LA	834 Member Linkage File	Daily
CHS-LA	Enrollment Broker	997 Functional Acknowledgement	Daily
Enrollment Broker	CHS-LA	834 Member Disenrollment File	Daily
CHS-LA	Enrollment Broker	997 Functional Acknowledgement	Daily

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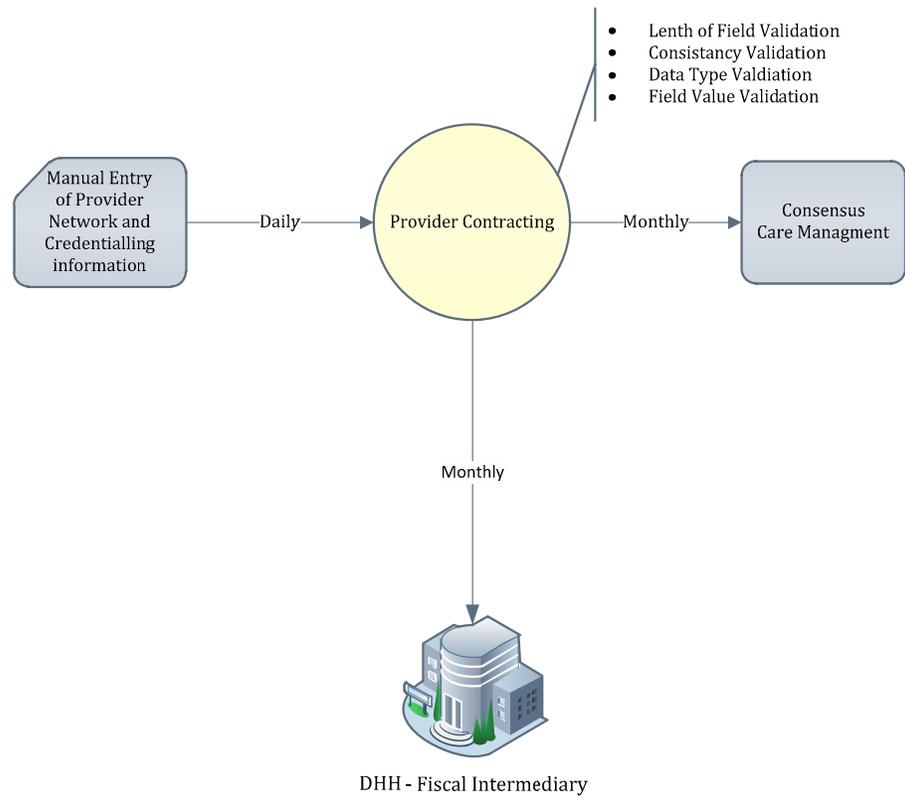
CHS-LA/ECD	CHS-LA /Consensus/Data Warehouse	Eligibility Update	Daily
DHH- FI	CHS-LA	820 Member Reconciliation File	Monthly
CHS-LA	DHH-FI	997 Functional Acknowledgement	Monthly
CHS-LA/ECD	CHS-LA /Consensus/Data Warehouse	Eligibility Reconciliation Update	Monthly
CHS-LA	DHH-FI	Member Demographic Update	As Mandated



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Network Provider Exchange

Responsible Party	Receiving Party	File/Report Name	Frequency
CHS-LA	DHH-FI	Network Provider and Subcontractor Registry	At Readiness Review
CHS-LA	DHH-FI	Network Provider and Subcontractor Registry	Monthly
CHS-LA/PCS	CHS-LA /Consensus	Provider Update	Monthly



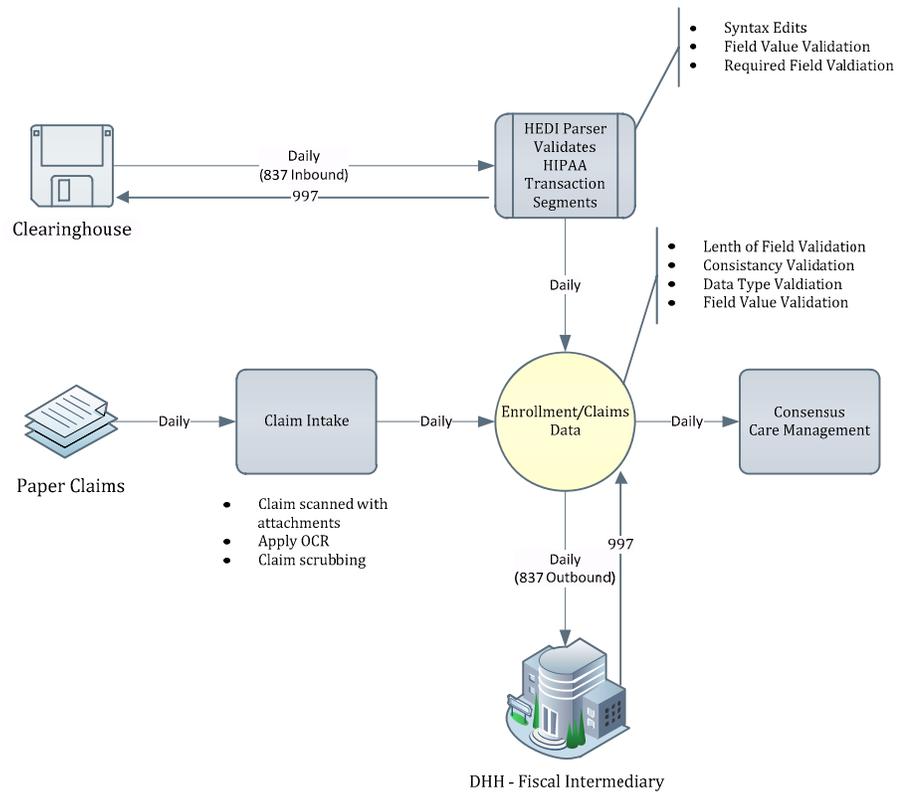
Community Health Solutions of Louisiana (CHS-LA)

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Claim Exchange

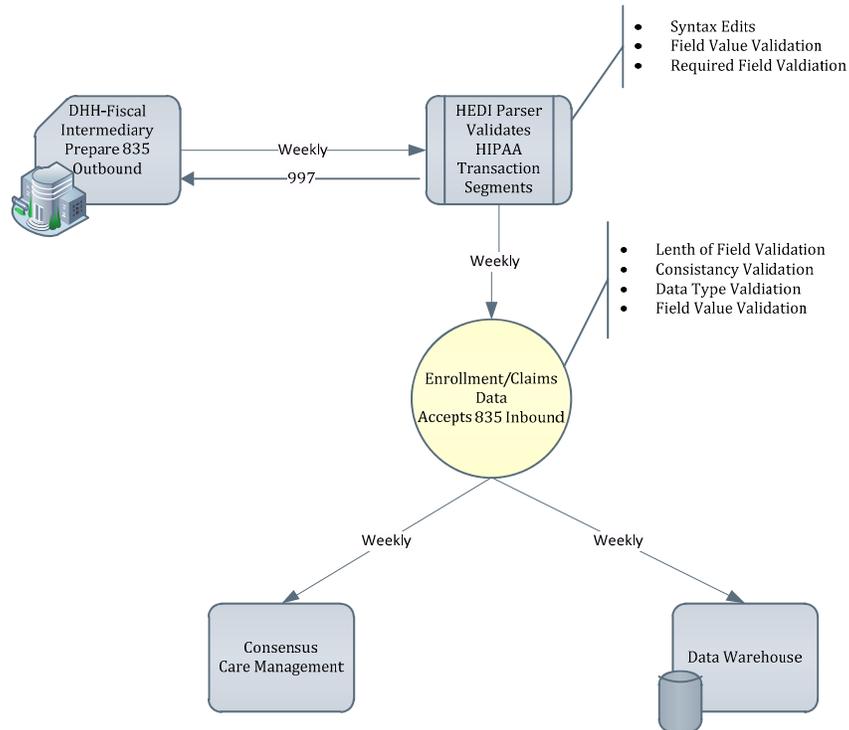
Responsible Party	Receiving Party	File/Report Name	Frequency
Clearinghouse	CHS-LA	837 I and P	Daily
CHS-LA	Clearinghouse	997 Functional Acknowledgement	Daily
CHS-LA	DHH-FI	837 I and P	Daily
DHH-FI	CHS-LA	997 Functional Acknowledgement	Daily
CHS-LA/PCS	CHS-LA /Consensus	Claim Update	Daily



Community Health Solutions of Louisiana (CHS-LA) CCN-S Proposal Submission Geographic Service Area: A, B, C

Finalized Claim Exchange

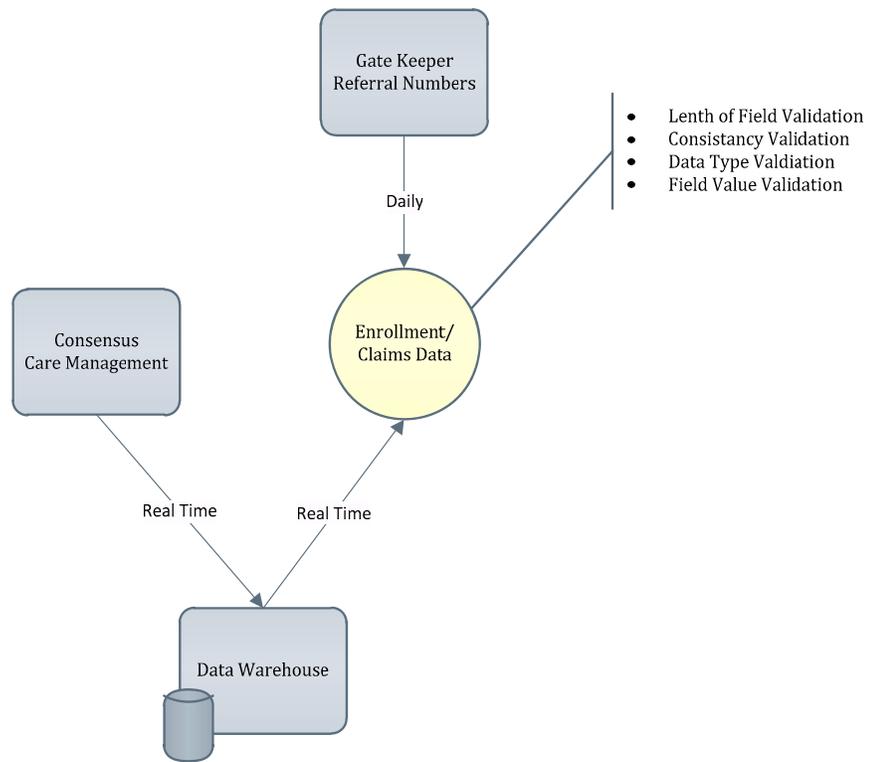
Responsible Party	Receiving Party	File/Report Name	Frequency
DHH-FI	CHS-LA	835	Weekly
CHS-LA	DHH-FI	997 Functional Acknowledgement	Weekly
CHS-LA/ECD	CHS/Consensus/ Data Warehouse	Claim Update	Weekly



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Service Authorization/Referral

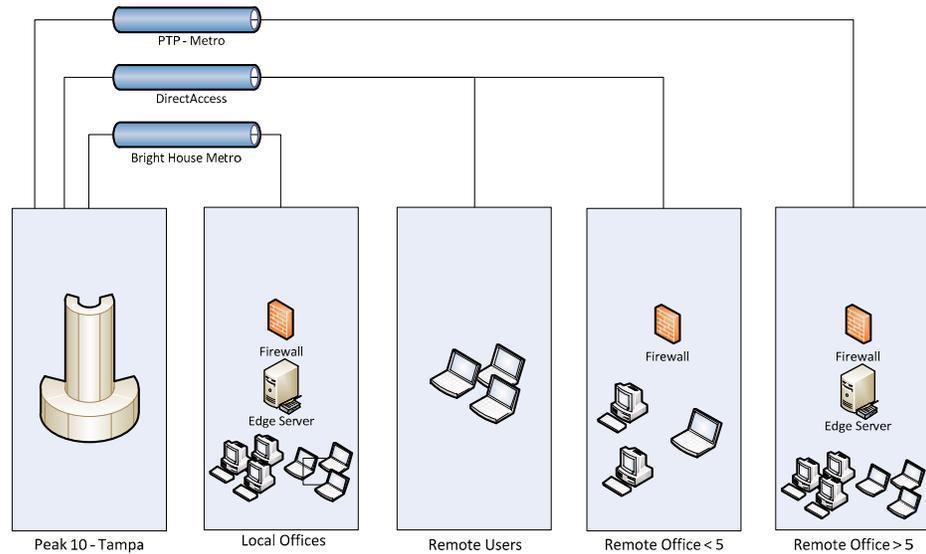
Responsible Party	Receiving Party	File/Report Name	Frequency
CHS-LA /Consensus	CHS-LA/Data Warehouse	Service Authorization	Real Time
CHS-LA/Data Warehouse	CHS-LA/ECD	Service Authorization	Real Time
External Gate Keepers	CHS-LA/ECD	Referral	Daily



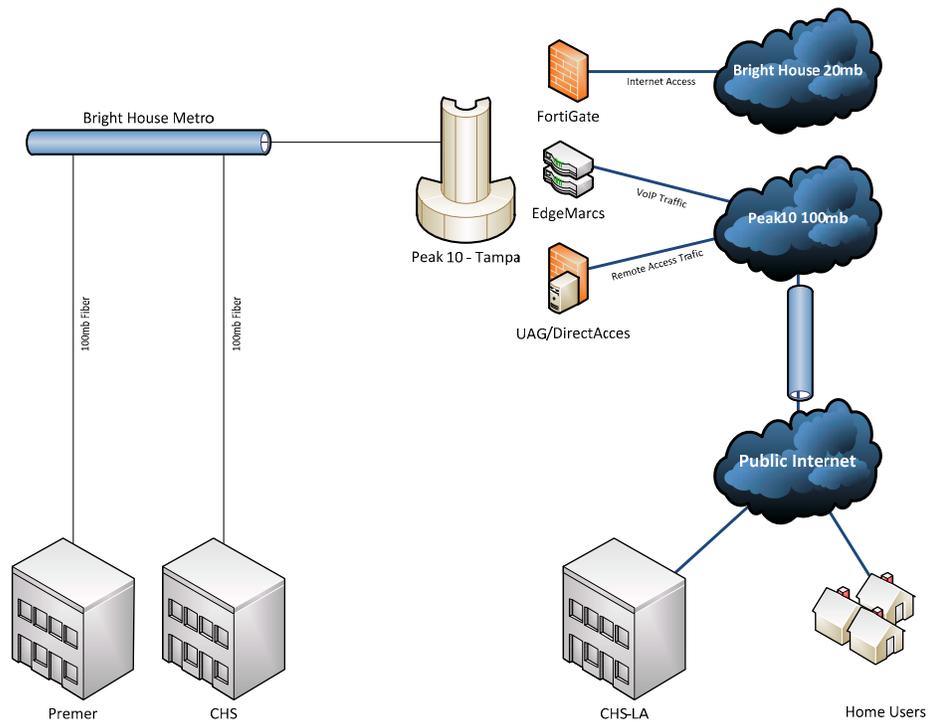
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Network Topology

Connectivity by Location

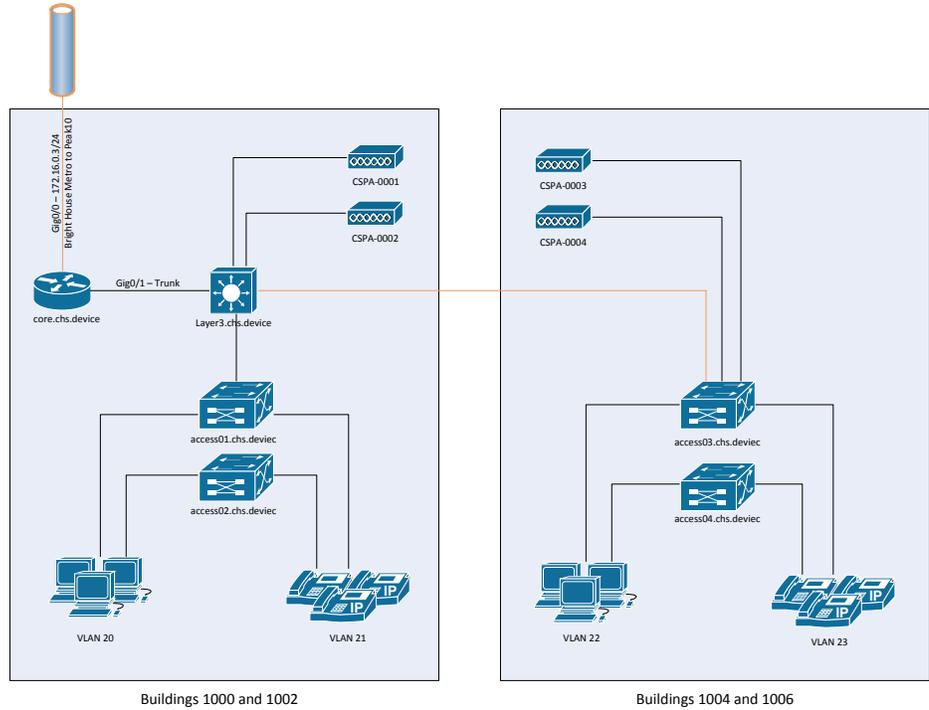


Overall Network

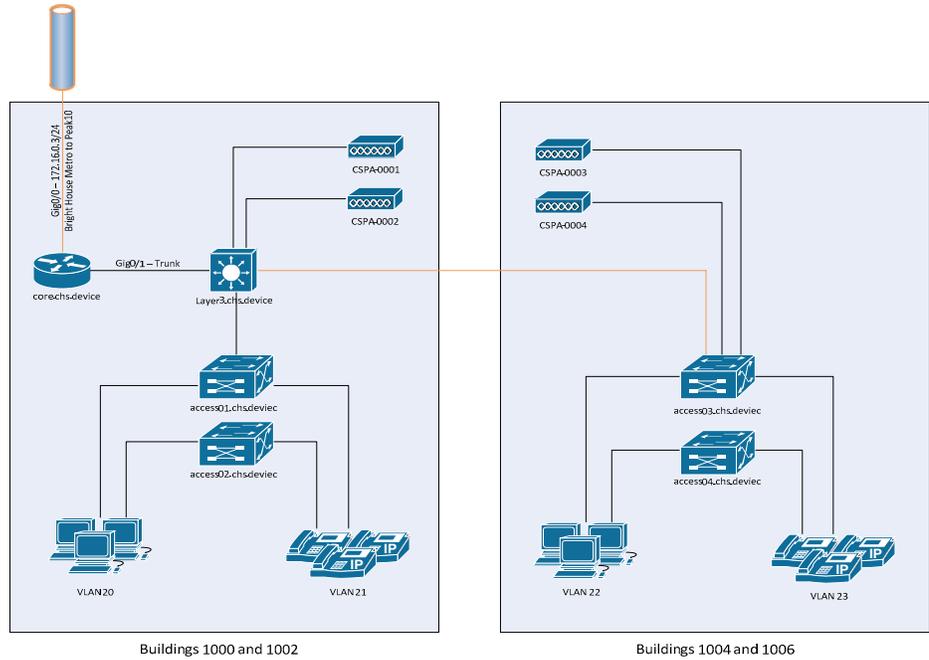


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Home Office

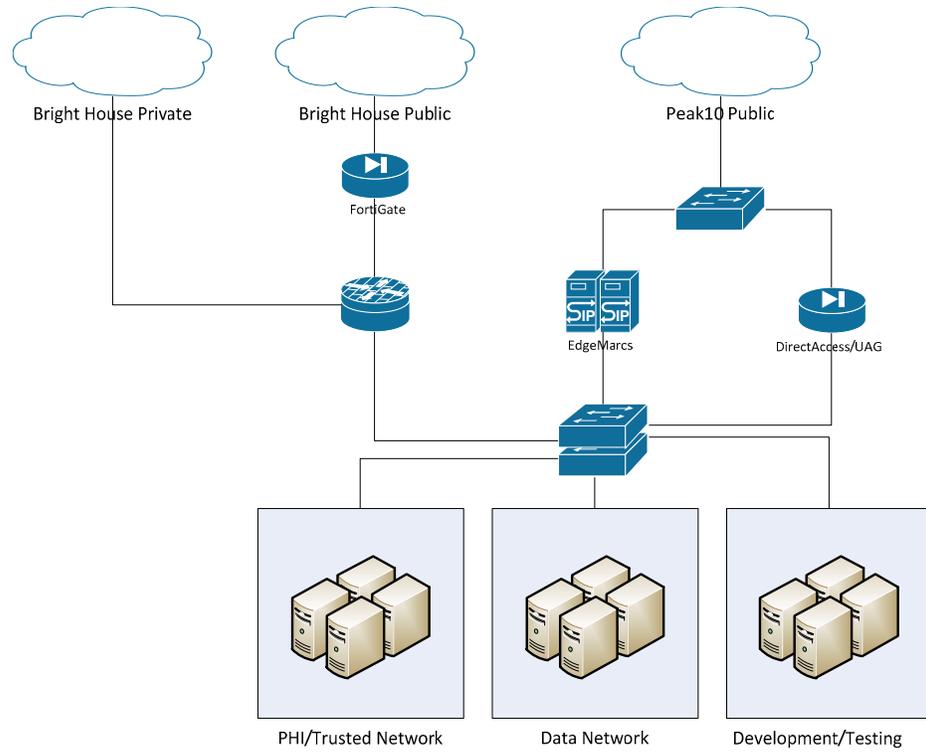


Remote Site



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Data Center



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Section Q: **Information Systems (Section 13 of RFP)**

Requirement Q.5: *Describe your ability to provide and store service/prior authorization data in accordance with the requirements in this RFP. In your response:*

- *Explain whether and how your systems meet (or exceed) each of these requirements.*
- *Cite at least three currently-live instances where you are successfully providing service/prior authorization functions in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications. Explain how previous or current experience will apply to the Louisiana Medicaid CCN Program.*
- *If you are not able at present to meet a particular requirement contained in the RFP, identify the applicable requirement and discuss the effort and time you will need to meet said requirement. (4) Identify challenges and “lessons learned” from your implementation and operations experience in other states and describe how you will apply these lessons to this contract.*

Response:

Community Health Solutions of Louisiana (CHS-LA) will utilize our Consensus Care Management (CCM) system to provide and store service/prior authorization data in accordance with the requirements set forth in the Request for Proposals (RFP). CCM auto generates a unique prior authorization ID for both participating and non-participating providers based on a user’s request for services. This number is used to track all activity. This data is automatically posted to the data warehouse on hourly intervals. Users that require real time access to service utilization information access the information through CCM. Other users and systems that access service utilization information do so through the data warehouse.

Authorization information is sent to the Fiscal Intermediary (FI) using the 837 file format via secure FTP.

Community Health Solutions of America (CHS) has had previous experience with prior authorization functions with several programs: Texas Chip, Florida Healthy Kids and Florida Comprehensive Health Association. Current clients do not require prior authorization, except for referral to non-participating providers.

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Using our prior and current technological experience, we are able to meet all requirements set forth in the RFP and will demonstrate our ability to implement and manage the LA Medicaid CCN-S program through:

- Integrating with 3rd parties.
- Reformatting provider, eligibility and claim data.
- Sending secure data.
- Creating service authorizations.
- Processing Medicaid claims.

Prior implementations have taught us that a successful integration project must have:

- strong communication between organizations enabled through:
 - Project Office
 - Project Plan at the task level
 - Readiness Review Board/Steering Committee
 - Issue Tracking
 - Risk Management
- Well documented policies and procedures.
- Frequent synchronization meetings to ensure all parties are aware of their responsibilities and on time with deliverables.

CHS' South Carolina based program, South Carolina Solutions (SCS) underwent a change in the method it received eligibility data and sent contracted provider data. The change involved moving from a proprietary enrollment file from the state and migrating to a HIPAA compliant 834 from an enrollment broker and submitting contracted provider information to the enrollment broker in a new format.

CHS' team, along with representatives from other MCO's, worked with the state and the enrollment broker for approximately one year to completely implement the change. The agile systems used by CHS allowed for the changes to be made, tested and incorporated in daily operations very quickly. SCS was one of the first health plans to be fully operational.

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Section Q: **Information Systems (Section 13 of RFP)**

Requirement Q.6: *Describe your ability to receive, process, and update eligibility/enrollment, provider data, and claims data to and from the Department and its agents; in accordance with the requirements in Section 14. In your response:*

- *Explain whether and how your systems meet (or exceed) each of these requirements.*
- *Cite at least three currently-live instances where you are successfully receiving, processing and updating eligibility/enrollment data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications. In elaborating on these instances, address all of the requirements in Section 14. Also, explain how that experience will apply to the Louisiana Medicaid CCN Program.*
- *If you are not able at present to meet a particular requirement contained in the aforementioned sections, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.*
- *Identify challenges and “lessons learned” from implementation in other states and describe how you will apply these lessons to this contract.*

Response: Community Health Solutions of Louisiana’s (CHS-LA) information system shall meet the requirements associated with the receiving, processing, updating, and exchanging of eligibility/enrollment, provider, and claims data in the following manner:

Eligibility/Enrollment

The enrollment/eligibility subsystem has the ability to track and identify numerous data elements, including, but not limited to:

- Other insurance coverage through Medicare or possibly another commercial carrier.
- Historical data files and transmission information for auditing.

The existing data elements supported as part of enrollment and eligibility are numerous and often exceed contractual requirements.

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Member data elements include:

- A unique identifier assigned to each Medicaid member.
- Medicaid ID.
- Effective date.
- Termination date.
- Disenrollment reason.
- Disenrollment type.
- Eligibility category.
- Demographic information.

All data is processed and stored for historical reference.

Internal edits are routinely performed on enrollment/eligibility data to:

- Maintain data quality.
- Ensure overall program integrity.

The Enrollment/Eligibility subsystem also supports:

- Acceptance of 834 X12 Transactions.
- Acceptance of 820 X12 Transactions.
- Production of 997 functional acknowledgement.
- Maintenance of historical data and files as required.
- Maintenance of data on enrollment/disenrollment activities, including reason or type of disenrollment.
- Processing updates within twenty-four (24) hours of receipt of enrollment files.
- Notification to DHH of member demographic changes.

This model has been successfully implemented in three states:

- South Carolina (Medical Home Program) - *Active*.
- Texas (S CHIP).
- Florida (S CHIP).

Through previous program implementations' "lessons learned", we have developed edits for conflict resolution. These edits include, but are not limited to:

- Retrieval translation, editing, and updating of files in accordance with program requirements prior to inclusion in the system.
 - Exception reports during the reconciliation process between new data and data existing in the system.
 - Identification of potential duplicate records with the ability to merge enrollment, utilization and customer service history.
 - Identification of retro disenrollments and retro reinstatements.
-

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These edits have been incorporated in the system and are part of the implementation of all programs.

Provider Data

The provider contracting subsystem has the capability of tracking numerous data fields for each provider to support the credentialing and re-credentialing process. These fields include:

- Provider demographics.
- Provider participation.
- Provider type.
- Specialty codes.
- Sub-specialty codes.
- Capacity or other limitations.
- Emergency arrangements and contacts.
- Affiliations.
- Restrictions/Sanctions.
- Ethnicity.
- Languages spoken.
- Office hours.

The provider credentialing subsystem also supports national provider numbering formats such as:

- NPI
- Taxonomy Code
- CLIA

All data is processed and stored for historical reference.

Personnel can monitor and report upon statistics such as:

- Physician to enrollment ratios for actual maximum.
- Total member enrollments by physician to determine capacity for that provider.
- Providers with restrictive conditions.

Both provider subsystems are used and work together to:

- Receive, process, and update provider information used by the Enrollment Broker to access and identify PCP's for member assignment.
 - Produce electronic data that contains information on all Medicaid providers for use in service authorizations and analysis.
 - Compile GeoAccess maps and reports to demonstrate access and availability of network providers supporting the program.
-

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This model has been successfully implemented in three states:

- South Carolina (Medical Home Program) - *Active*.
- Texas (S CHIP).
- Florida (S CHIP).

Through previous program implementations “lessons learned” we have found that the frequency of updates of network providers to the Enrollment Broker is critical. The Louisiana program currently requires monthly updates. CHS-LA recommends that, at a minimum, weekly updates of provider data be transmitted to the Enrollment Broker.

Claims Data

The Claims subsystem supports the collection, processing, and storage of claims data for all services delivered to CHS-LA members. The system includes functionality such as:

- Confirmation of approval and denials of service authorizations provided by the Utilization Management Module during the pre-processing of claims.
- Reporting of the service authorization number in loop 2300, REF02, data element 127. The number will not exceed 16 digits and will be in a numeric format. A reference identification qualifier value of G1 will be used in REF01, data element 128.
- Validation of service authorizations and services, based on eligibility provided by DHH.
- Verification of medical necessity, based on benefit rules as defined by DHH.
- Capturing of all date iterations of the claim including: date received by CHS-LA, date returned to the provider for additional information, date sent to FI, date paid by FI.
- Assignment of an internal control number (ICN) based on the Julian date on which the claim was pre-processed. The ICN will be populated in loop 2300, Medical Record Number, REF02, data element 127. The reference identification qualifier value of EA will be used in REF01, data element 128.
- Capturing and submission of the provider’s NPI, Taxonomy Code and 9 - digit zip code for each encounter.
- Use of applicable Category II CPT Codes or HCPCS Level II G-codes for performance measurement.
- Reporting in the ASC X12N 837 professional health care claim transaction, Category II CPT and HCPCS Level II codes submitted in the SV1 “Professional Service” Segment of the 2400

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“Service Line” Loop. The data element for the procedure code is SV101-2 “Products/Service ID”. The segment that the Category II/HCPCS Level II G-code will be identified by submitting “HC” code for data element SF101-1.

- Pre-processing of claims and tracking of service utilization data.
- Approving, preparing for payment, or rejecting/denying of submitted claims through integrated systems.
- Application of edits to ensure allowed services are provided to eligible enrolled members by eligible providers.
- Auditing to ensure that the claims’ pre-processing requirements and service authorization procedures are met.
- Utilization of fee schedules and benefit rules for pre-processing claims.
- Utilization of Ingenix claims edit knowledge base to detect coding errors.
- Supporting all functions required for claims pre-processing.
- Ensuring that clean claims received from providers will be transmitted to the FI within two (2) business days of receipt.
- Ensuring that reports are available on all required data elements, including the ability to create an audit report to demonstrate the percentage of claims submitted to the FI within two business days of the date a clean claim has been received from a provider.
- Ensuring that all complaints by providers are tracked, including delayed payment complaints.
- Providing call center resources for providers to obtain service authorization status information.

Currently the system does not provide on-line capabilities to providers to obtain service authorization status information. CHS-LA is in the process of web enabling this service. The expected effort is minimal using current technology and our service oriented architecture. The function will be available at readiness review.

Claim Formats

The system is capable of exchanging and transmitting data electronically using the appropriate ANSI ASC X12 EDI formats or other DHH specified formats. CHS-LA will obtain a submitter identification number from the FI prior to submitting claims. Files include, but are not limited to:

- 837 transactions (P - Professional, I - Institutional).
 - 835 transactions.
 - 997 functional acknowledgment.
-

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CHS-LA understands that transaction types are subject to change and will comply with applicable federal and HIPAA standards and regulations as they occur.

CHS-LA will not revise or modify the standardized forms or formats and will adhere to national standards and standardized instructions and definitions that are consistent with industry norms, developed jointly with DHH. These shall include, but not be limited to:

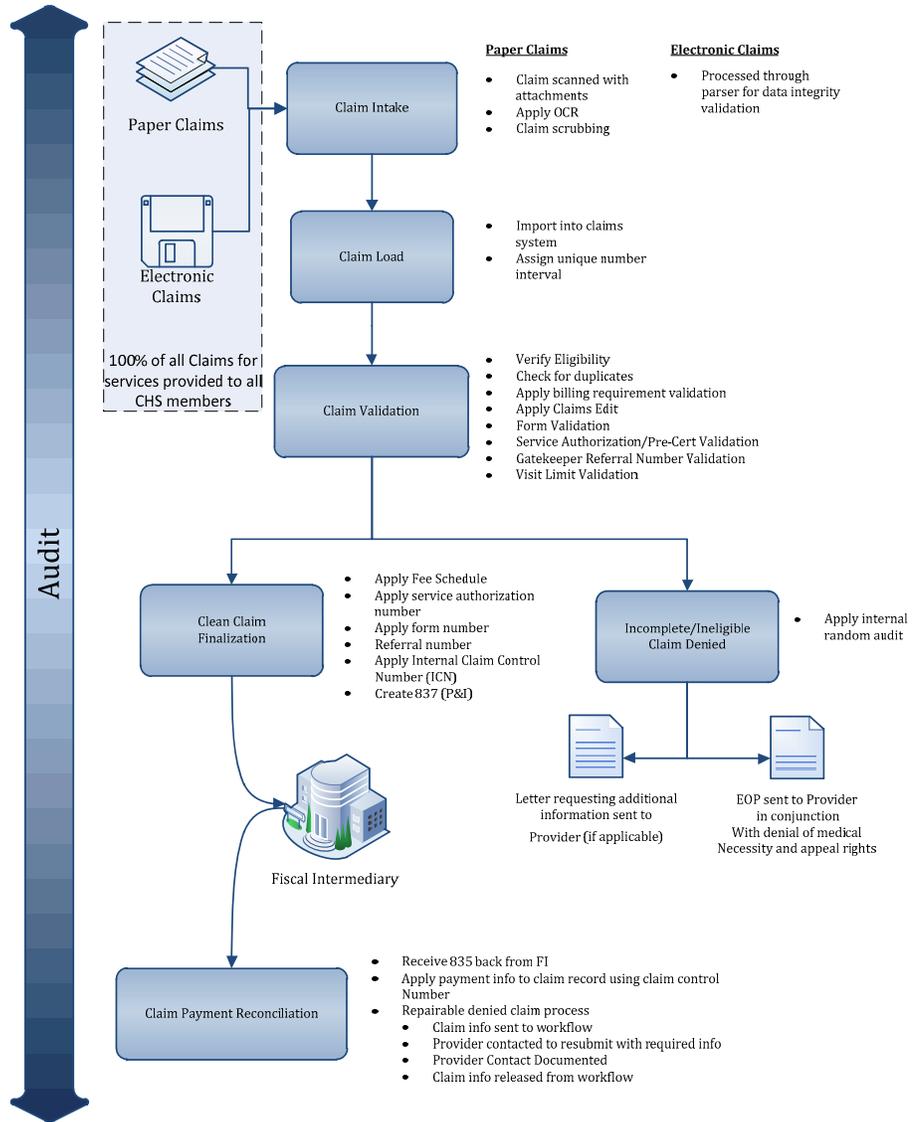
- HIPAA based standards.
- Federally required safeguard requirements including signature requirements described in the CMS State Medicaid Manual.

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Claims Model Workflow



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Service Authorization Disputes

CHS-LA will take the following steps to address Service Authorization Disputes:

- CHS-LA will develop internal claims dispute procedures that will be reviewed by DHH within thirty (30) days of Contract signature and prior to any changes in the procedures.
- CHS-LA will develop internal peer-to-peer review policies and procedures.
- CHS-LA shall adhere to the appeals process outlined in the Contract.
- CHS-LA shall utilize its system to capture, and be able to report on, the status and resolution of all authorization disputes as well as all associated documentation.

Remittance Advices and Related Functions

CHS-LA will accept, from the FI, an electronic status report indicating items such as:

- Disposition of every adjudicated claim for each claim type submitted by providers seeking payment.
- Appropriate explanatory remarks related to payment of a claim

CHS-LA will assist providers in submitting additional information, when required, using the repairable denial codes submitted by the FI.

Payment Cycles

CHS-LA will submit claims daily to the FI. The FI will process claims in weekly batch cycles. Claims received on or before 10:00 a.m. each Thursday will be processed in that week's batch cycle.

National Coding Initiative

CHS-LA will comply with the requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), regarding "Mandatory State Use of National Correct Coding Initiatives," including all applicable rules, regulations, and methodologies implemented as a result of this initiative.

Self Audit Requirements

CHS-LA will employ self auditing processes to ensure that ninety-nine percent (99%) of clean claims received will be forwarded to the FI within

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two (2) business days. All claims will be time and date stamped upon receipt from the provider, whether received in paper or in electronic 837 format. The Julian date of receipt and date of submission to the FI will be provided.

In addition, random audits will be conducted to ensure:

- Accuracy of claims pre-processing.
- Accuracy of claims paid by FI.

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Section Q: **Information Systems (Section 13 of RFP)**

Requirement Q.7: *Describe the ability within your systems to meet (or exceed) each of the requirements in Section 13 - System and Technical Requirements. Address each requirement. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.*

Response: This response is based upon Section 13 of the Request for Proposals (RFP) System and Technical Requirements.

Community Health Solutions of Louisiana (CHS-LA) has the ability, using current system functions, to maintain an automated Management Information System (MIS) that:

- Accepts provider claims.
- Verifies eligibility.
- Validates prior authorizations.
- Pre-processes claims.
- Submits claims data to DHH-FI for payment on a fee-for-service basis.

The system will meet all requirements of the RFP, as well as all state and federal laws, rules and regulations, including:

- Medicaid confidentiality.
- HIPAA.
- American Recovery and Reinvestment Act (ARRA).

The system has the ability to:

- Maintain capacity sufficient to handle the workflow projected for the begin date of operations.
- Is scalable and flexible so that it can be adapted as needed and within specified timeframes.
- Provide service authorizations for all services requiring authorization.

CHS-LA will meet, as requested by DHH, with work groups and committees to:

- Coordinate activities.
- Develop system strategies.
- Actively reinforce the healthcare reform initiative.

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As required by DHH, CHS-LA will incorporate, to any degree required, with DHH's web presence/portal and conform to all applicable state standards for:

- Website structure.
- Website coding.
- Website presentation.

13.1 Data and Document Management Requirements

13.1.1 Adherence to Standards

The system conforms and adheres to the data and document management standards of the Fiscal Intermediary (FI) including standard transaction code sets such as:

- 834 Benefit Enrollment and Maintenance.
- 837I Institutional Claim/Encounter Transaction.
- 837P Professional Claim/Encounter Transaction.

13.1.2 Confidentiality, Privacy, and Security

CHS-LA will comply with all state and federal confidentiality requirements including, but not limited to:

- HIPAA standards for data and document management.
- HIPAA standards for security.
- HIPAA standards for privacy.

13.1.3 System Accessibility

CHS-LA's data warehouse utilizes SQL Server 2008 technology. The data warehouse serves as the central repository of data from the various CHS-LA's source systems. Currently the data warehouse is updated hourly by extract, transform and load (ETL) processes. These processes can be modified as necessary and can run in real time if required.

CHS-LA's reporting solution is delivered through the Microsoft Suite of products; specifically SQL Server Reporting Services (SSRS) and SQL Server Integration Services (SSIS).

13.1.4 Data and Document Relationship

All documents for a member are stored in the member's Documents module, and are linked to the member by a system generated unique Member ID. The Member ID is the key that links any and all member data together, such as Demographics which contain the Member identification numbers, the Utilization Management and Referral modules that contain service authorization numbers, the Referral and Medication modules that contain the provider identification numbers, and the claims module which contains the claim identification numbers. Any digital file can be imported into Consensus via the

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Documents module and is attached to a specific member. Additionally, all member specific documents generated by the Consensus system, such as Assessments, Educations, Care Plans and Letters, are automatically stored in the Documents module linked to that member. The Consensus system ensures that all records associated with a common event, transaction or customer service issue have a common index that facilitates search, retrieval and analysis of related activities.

13.1.5 Retention

CHS-LA utilizes Optical Character Recognition (OCR) for all documents received. These documents are housed in the Enrollment/Claims Data system (ECD) and can be accessed via the Medicaid ID, Provider ID and/or Internal Control Number (ICN).

DHH will have the ability to access documents for six (6) years in live systems for audit and reporting purposes, and ten (10) years in archived systems.

CHS-LA will not archive or purge data for services that have a “once in a life-time” indicator and will use the DHH’s formulary to identify these services.

CHS-LA will provide forty-eight (48) hour turnaround time or better on requests for access to information in machine readable form that is between six (6) to ten (10) years old.

13.1.6 Information Ownership

CHS-LA agrees that all information, whether data or documentation, and reports that contain or reference information involving or arising out of this RFP is owned by DHH. CHS-LA will not share or publish DHH’s information or reports without prior written consent for DHH. Further it is understood that, in the event of a dispute regarding sharing or publishing of information and reports, DHH’s decision will be final.

13.2 System and Data Integration Requirements

13.2.1 Adherence to Standards for Data Exchange

CHS-LA has the ability to transmit, receive, and process data in HIPAA-compliant or when required DHH specific formats. Methods of file transfer include, but are not limited to:

- Secure File Transfer Protocol (FTP) over a secure connection such as a Virtual Provider Network (VPN)

CHS-LA will demonstrate this functionality at Readiness Review.

Desktop Workstation Hardware:

- Intel Core i5 2.6GHz.
 - 4GB of RAM.
-

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- 250GB 10krpm Hard Drive.
- Minimum 256 discrete video memory.
- Dual monitors with no less than 1440x900 screen resolution.
- DVD/CD Burner.
- Intel gigabit Ethernet Card.

Desktop Software

- 64bit Windows 7 Enterprise.
- Microsoft Internet Explorer v8.0 migrating to v9.0.
- Microsoft Outlook.
- Office 2010 Professional Plus.
- Internet Access.
- WinZIP v11.0 or later.
- Anti-virus and anti-malware - Microsoft Essentials updates occur nightly.
- Anti-spam handled at the firewall.

Laptop Hardware:

- Intel Core i5 2.6GHz.
- 4GB of RAM.
- 250GB 7200rpm Hard Drive.
- Minimum 256 MB discrete video memory.
- Monitor with no less than 1440x900 screen resolution.
- DVD/CD Burner.
- Intel gigabit Ethernet Card.

Laptop Software

- 64bit Windows 7 Enterprise.
- Microsoft Internet Explorer v8.0 migrating to v9.0.
- DirectAccess.
- Microsoft Outlook.
- Office 2010 Professional Plus.
- Internet Access.
- WinZIP v11.0 or later.
- Anti-virus and anti-malware - Microsoft Essentials updates occur nightly.
- Anti-spam handled by the firewall.
- BitLocker + Key - Provides full disk encryption with two factor authentication.

CHS-LA will comply with DHH's Electronic Claims Data Interchange and obtain annual certification of electronically submitted claims.

13.2.2 HIPAA Compliance

As part of CHS-LA's commitment to quality, all data exchanges between CHS-LA and DHH will be subject to the highest level of

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compliance which will be measured by an industry-standard HIPAA compliance checker.

13.2.3 Connectivity and Interoperability

All CHS-LA's applications, operating software, middleware, and networking hardware will be interoperable with DHH's systems as needed and will conform to applicable standards and specifications set forth by DHH. The system will 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.

CHS-LA maintains computer hardware and software that provides the following established capabilities:

- All offices within our span of control are networked using industry standard Cisco equipment. Each location is connected to our datacenter via secure means.
- Each PC within CHS-LA's span of control has access to the Internet via an aggregated connection protected by an appropriate firewall device.
- All public Internet entry points are protected via industry standard firewall devices. Each device is capable of rules based filtering, as well as Intrusion Prevention System (IPS) policies and data leak prevention. All publicly facing servers segmented into a DMZ to prevent any unauthorized access to internal servers.
- All workstation data is stored on central servers and backed up nightly. Server data is also backed up nightly and kept within our backup infrastructure.
- All network equipment is protected via appropriate UPS/Surge Protection devices. Devices that support dual power are connected to at least two unique UPS devices.
- Should the length of a power loss exceed the amount of available power from battery backups, our datacenter is equipped with diesel generators capable of running the facility for a minimum of one week.

13.2.4 Program Integrity (Fraud and Abuse)

The system is capable of generating files in the prescribed formats of the FI to be used specifically for program integrity purposes. Reporting tools are available that will enable DHH, FI or other DHH authorized staff secured views, with associated authorization making data available for reporting.

13.3 Pre-Processed Claims Data Submission

The CHS-LA system conforms to HIPAA standard codes sets such as:

- 834 Benefit Enrollment and Maintenance.
- 837I Institutional Claim/Encounter Transaction.

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- 837P Professional Claim/Encounter Transaction.

All pre-processed clean claims will be electronically submitted to the FI using standard transaction formats within two (2) business days of receipt of a clean claim.

13.3.1.1

All claims will be submitted to the FI electronically in the standard HIPAA transaction formats.

- ANSI X12N 837I
- ANSI X12N 837P

13.3.1.2

Codes are updated based on HIPAA standards. Codes updated include, but are not limited to:

- ICD-9
- CPT
- HCPCS

13.3.1.3

To aid in the measurement of quality performance the following codes will also be used:

- HCPCS Level II
- CPT Category II

13.3.1.4

CHS-LA will provide the FI complete and accurate claims data.

13.3.2

In the event MMIS identifies errors in CHS-LA's batch claims submission, CHS-LA will immediately correct problems identified.

13.3.3

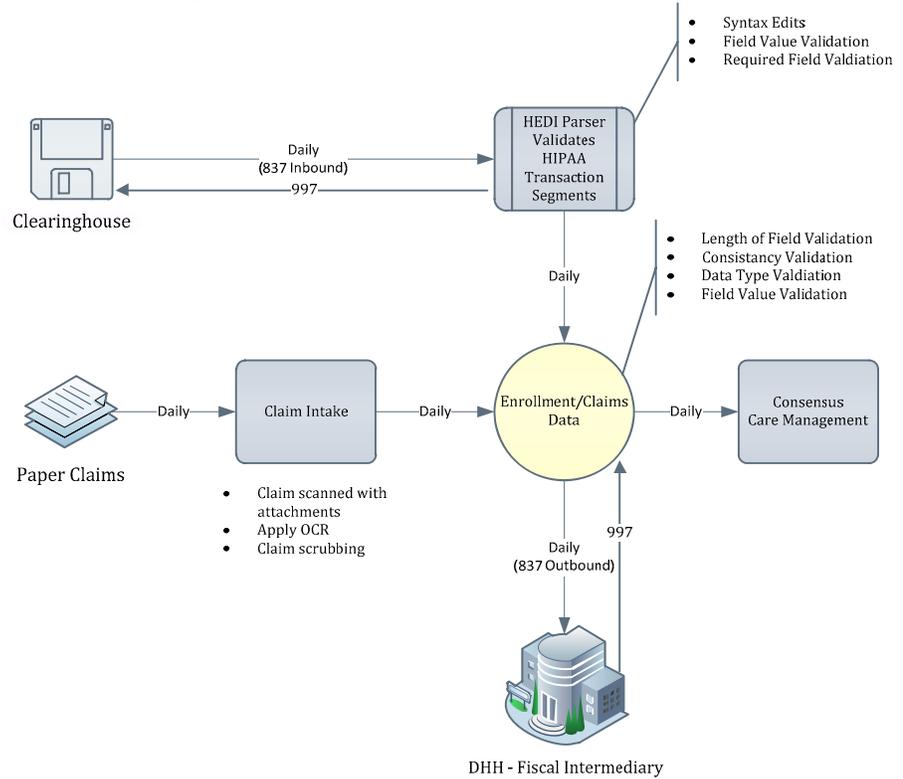
CHS-LA will use DHH provider billing manuals during the development of the systems pre-processing business rules. All issues that prevent processing of a claim will be addressed using defined remediation rules to maintain integrity of processing sequence.

Claims Exchange Schedule

Responsible Party	Receiving Party	File/Report Name	Frequency
Clearinghouse	CHS-LA	837 I and P	Daily
CHS-LA	Clearinghouse	997 Functional Acknowledgement	Daily
CHS-LA	DHH-FI	837 I and P	Daily
DHH-FI	CHS-LA	997 Functional Acknowledgement	Daily
CHS-LA/PCS	CHS-LA /Consensus	Claim Update	Daily

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Claims Exchange Diagram

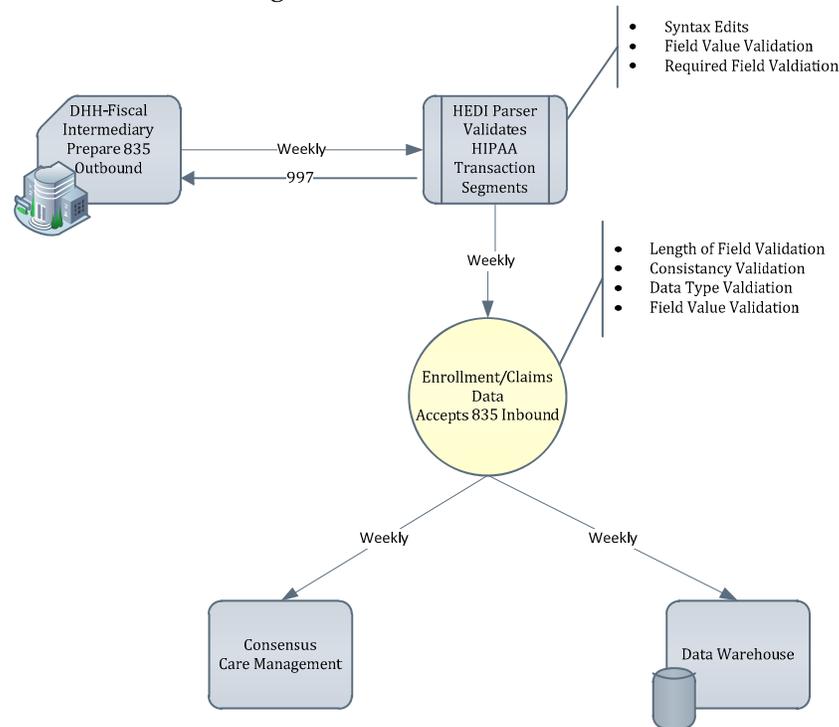


Finalized Claims Schedule

Responsible Party	Receiving Party	File/Report Name	Frequency
DHH-FI	CHS-LA	835	Weekly
CHS-LA	DHH-FI	997 Functional Acknowledgement	Weekly
CHS-LA/ECD	CHS/Consensus/Data Warehouse	Claim Update	Weekly

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Finalized Claims Diagram



13.4 Eligibility and Enrollment Data Exchange

13.4.1 The system has the proven ability to process Eligibility and Enrollment Data. CHS-LA will:

- Receive, process and update enrollment files sent on a daily basis from the Enrollment Broker.
- Make updates to eligibility in all databases within the specified window of twenty-four (24) hours.
- Transmit to DHH in the specified formats and methods in the HIPAA guide, or as otherwise specified by DHH, Member demographic changes such as:
 - Address.
 - Telephone number.
- Assign a unique identifier (current system attribute: MemberId) to each Medicaid Member across multiple populations in systems within its span of control.
- Identify potential duplicate records based on DHH definitions of duplication and report suspected duplicates to DHH. Upon confirmation of said duplicate record by DHH, records will be

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merged or linked. Duplicate records consist of but are not limited to the following:

- Enrollment.
- Service utilization.
- Customer inquiries.

Eligibility Exchange Schedule

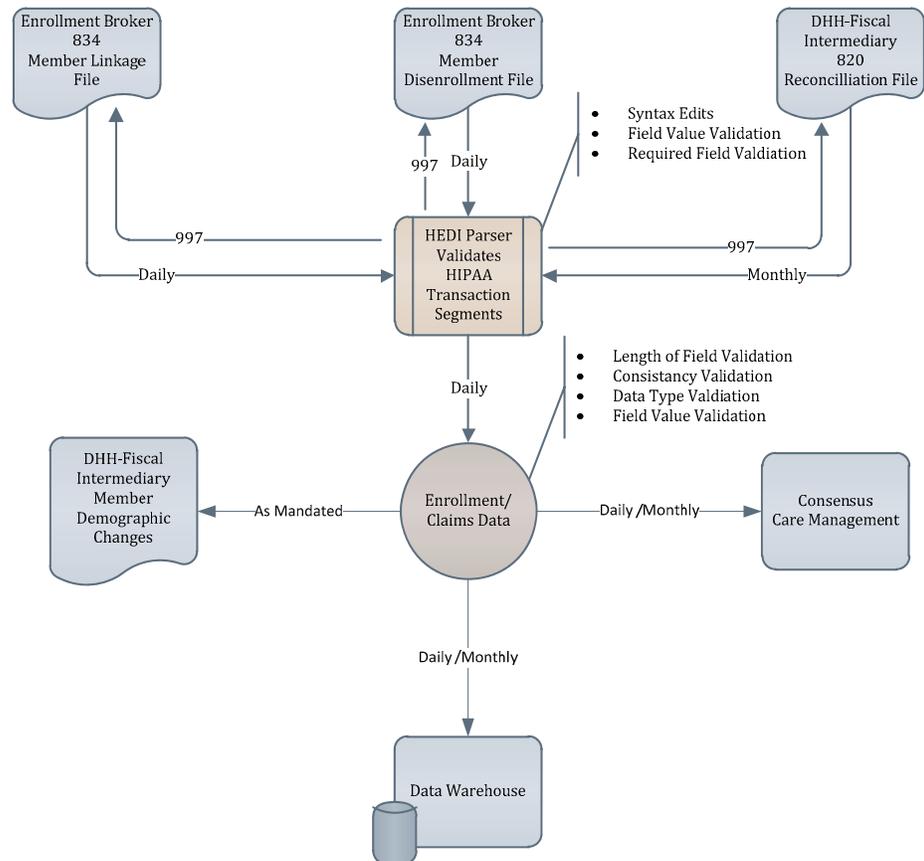
Responsible Party	Receiving Party	File/Report Name	Frequency
Enrollment Broker	CHS-LA	834 Member Likage File	Daily
CHS-LA	Enrollment Broker	997 Functional Acknowledgement	Daily
Enrollment Broker	CHS-LA	834 Member Disenrollment File	Daily
CHS-LA	Enrollment Broker	997 Functional Acknowledgement	Daily
CHS-LA/ECD	CHS-LA /Consensus/Data Warehouse	Eligibility Update	Daily
DHH- FI	CHS-LA	820 Member Reconciliation File	Monthly
CHS-LA	DHH-FI	997 Functional Acknowledgement	Monthly
CHS-LA/ECD	CHS-LA /Consensus/Data Warehouse	Eligibility Reconciliation Update	Monthly
CHS-LA	DHH-FI	Member Demographic Update	As Mandated

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Eligibility Exchange Diagram



13.5 Provider File

Based on DHH's schedule, CHS-LA will retrieve a Medicaid provider list published by DHH at the agreed upon location. The list will include:

- Provider types.
- Specialty codes.
- Sub-specialty codes.

CHS-LA will use these codes within the provider record for consistency between DHH and the Enrollment Broker.

13.5.1

CHS-LA has the ability to:

- Electronically receive process and update provider information within the CHS-LA network to enable enrollment broker access.
- CHS-LA will create an electronic file of all Medicaid providers for service authorization and analysis purposes.

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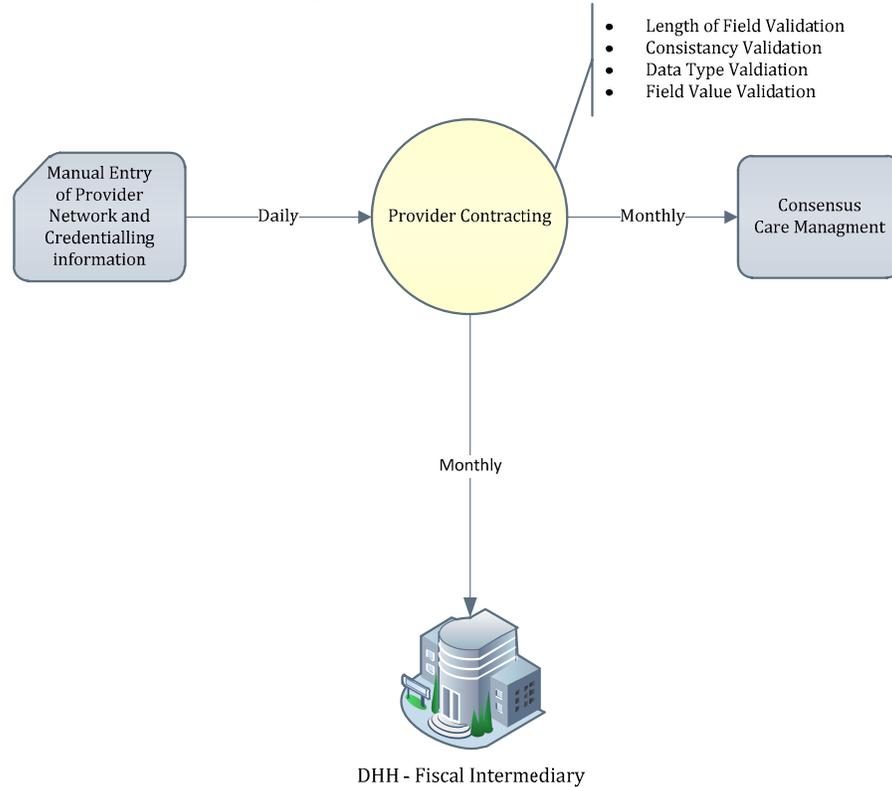
- The provider file includes the following data elements and functionality:
 - Linkages of individual providers to groups.
 - Provider office hours.
 - PCP Capacity.
 - Provider languages spoken.
 - Additional data elements captured are items such as:
 - Provider demographics.
 - Provider participation.
 - Provider type.
 - Specialty codes.
 - Sub-specialty codes.
 - Capacity or other limitations.
 - Emergency arrangements and contacts.
 - Affiliations.
 - Restrictions.
 - Ethnicity.
 - Gender.

Provider Exchange Schedule

Responsible Party	Receiving Party	File/Report Name	Frequency
CHS-LA	DHH-FI	Network Provider and Subcontractor Registry	At Readiness Review
CHS-LA	DHH-FI	Network Provider and Subcontractor Registry	Monthly
CHS-LA/PCS	CHS-LA /Consensus	Provider Update	Monthly

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Provider Exchange Diagram



13.6 System, Information Security and Access Management

CHS-LA's system utilizes access management functions that restrict user access at various levels.

Depending on user role, the privileges to view data include:

- Read
- Inquiry Only
- No Access

13.6.1.1.2

Users that view and change data do so through application interfaces which are controlled by role based function/action security. Users with global access will be restricted to staff jointly agreed to by DHH and CHS-LA.

13.6.1.1.3

Three unsuccessful attempts to access the system results in the systematic termination of the user credentials. Logs of these occurrences are maintained by the system.

13.6.1.2

CHS-LA is able to make available, to authorized representatives of

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DHH and other state and federal agencies to evaluate, through inspections or other means, the following system information:

- Quality of services performed.
- Appropriateness of services performed.
- Timeliness of services performed.

13.6.1.3

To maintain information integrity, security controls are in place at all appropriate points in processing. These controls will periodically be tested and spot audited based on a methodology developed by and mutually agreed upon by DHH and CHS-LA.

13.6.1.4

The systems used by CHS-LA have audit trails incorporated to make available information on source data files and documents. These audit trails (who, how, when) allow items to be traced through processing stages from initial entry to final processing.

13.6.1.4.1

Audit trails contain such items as:

- Log on ID.
- Date and time of all create/modify/delete actions.
- If processed by an automated system job, the ID of the system job that performed the action.

13.6.1.4.2

The system maintains the identification ID (user or automated process ID) and date/time of record changes. This information is viewable through the applications user interface.

13.6.1.4.3

Data and documents can be traced from point of entry/receipt to final source data file. For example, all member medical record changes can be traced back to a claim, or member or physician contact.

13.6.1.4.4

Audit trails are supported by using:

- Transaction logs.
- Activity Logs.
- Historical Audit Tables.
- Application Error logs.

13.6.1.4.5

The system has the ability to facilitate the auditing of individual records as well as batch auditing through:

- Targeted reporting.
 - Control totals both records and financial totals.
 - First and last record processing.
-

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- Duplicates.

13.6.1.4.6

Historical data will be maintained:

- On line for no less than six (6) years.
- Historical for no less than ten (10) years.

CHS-LA will provide forty-eight (48) hour turnaround or better on requests for access to information in machine readable form that is between six (6) to ten (10) years old.

13.6.1.5

The system prevents the alteration of records in a finalized status via security. In addition, finalized medical record information is rendered and stored as a PDF document to maintain historical state.

13.6.1.6

All server hardware is housed in a SAS70/SSAE16 Type II datacenter. CHS-LA will provide DHH access to this facility upon request.

13.6.1.7

Physical access to the datacenter by internal employees is limited to the fewest number possible. Each employee must use a keycard + PIN code, as well as pass a fingerprint scan to enter the main facility. Inside the datacenter, each rack is locked with a unique combination lock.

13.6.1.8

All hardware is housed in a SAS70/SSAE16 Type II datacenter supported by highly skilled technical personnel twenty-four (24) hours a day, seven (7) days a week. Physical security features include:

- Uninterruptible Power - The data center is engineered with an uninterruptible power system and backup generator to deliver seamless power. In the event of a commercial power failure, the isolated UPS system will provide immediate backup power. The diesel generators take over the load to continue operation of the center.
- Redundant Heating, Ventilating and Air Conditioning (HVAC) - Best-in-class environmental units are used to control and monitor the temperature and humidity in the data center facility. The redundant HVAC system keeps the average temperature in the data center at 70 degrees Fahrenheit to ensure a consistent operating atmosphere for CHS-LA's mission critical technology infrastructure.
- Fire Suppression - The datacenter utilizes dry-fire suppression systems that can be deployed manually, or by a sequence of three failures anywhere in a data center zone. The facility is also equipped with smoke and heat detection sensors as well as

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fire doors and handheld gas-based fire extinguishers.

13.6.1.9

Each public entry point within CHS-LA's span of control is protected by firewall appliances housed in the secure datacenter. Each firewall uses rule based filtering to permit the least amount of traffic required to fulfill the service requirement. The firewall devices include IPS policies to further analyze the incoming and outgoing traffic. Servers storing PHI, or other confidential data, are further protected by internal firewalls that limit internal traffic to the minimum amount required. This setup allows CHS-LA to isolate both public traffic and protected traffic to help limit our exposure to outside threats.

13.6.1.10

Remote users outside the CHS-LA firewall protected network will have access through industry standard ForteGate VPN with high encryption transmission plus userid/password authentication via Active Directory.

13.6.1.11

CHS-LA currently complies within other states with recognized industry standards governing security of state and federal automated data processing systems and information processing. CHS-LA will contract with Navigant Consulting, Inc. (or similar firm) to perform a security risk assessment. The results of this assessment will be available at readiness review.

13.7 System Availability

13.7.1

CHS-LA shall address requirements as follows:

13.7.1.1

Our datacenter facility is equipped with redundant internet connections from multiple providers. In the event that one provider drops, the internet traffic is automatically transitioned to a secondary provider.

The infrastructure of our call center phone system has both system redundancy within the application as well as geographical redundancy with data centers in Salt Lake City, Utah, Los Angeles, California and Dallas, Texas, sufficient to provide twenty-four (24) hours a day, seven (7) days a week IVR availability.

13.7.1.2

CHS-LA currently provides systems availability to users requiring

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8a.m. – 7p.m. EST and will adjust this to DHH requirement to 7a.m. – 7p.m. Central Time, Monday through Friday.

13.7.1.3

All systems and processes, within the control of CHS-LA, that are associated with data exchanges with the FI and/or Enrollment Broker will be available and operational based on current and modified to DHH SLA setup with our hardware, network and Software running within.

13.7.1.4

To ensure the availability of core processing system, CHS-LA has Service Level Agreements (SLAs) in place with key hardware vendors such as Dell Incorporated in the event of failures. Furthermore, we have access to identical non-production hardware that can be easily converted to a production system. Current disaster recovery plan are designed for forty-eight (48) hour recovery which exceeds the DHH seventy-two (72) hour requirement.

13.7.1.5

CHS-LA will notify the applicable DHH staff via phone, fax and/or electronic mail within sixty (60) minutes upon discovery of a problem with or outside CHS-LA's control. Notifications will be provided for items including but not limited to:

- Availability or performance of critical system functions.
- Problems impacting scheduled data exchanges.

Notification shall include a detailed description of impact on critical path processes.

13.7.1.6

CHS-LA will notify the applicable DHH staff via phone, fax and/or electronic mail within fifteen (15) minutes upon discovery of a problem that will result in the delay of:

- Report distribution.
- On-line access to critical system functions.

13.7.1.7

In the event of system unavailability, CHS-LA will provide applicable DHH staff with status updates. These updates will be in the form of telephonic and/or electronic mail and will be provided, at a minimum, hourly.

13.7.1.8

CHS-LA will resolve and implement system restoration:

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- Within sixty (60) minutes of official declaration of unscheduled system unavailability caused from the failure of critical functions technologies within CHS-LA's control.
- Within eight (8) hours of official declaration of unscheduled system unavailability for all other technologies within CHS-LA's control.

13.7.1.9

Cumulative unavailability for systems and/or IS infrastructure technologies within CHS-LA's span of control will not exceed twelve (12) hours during any continuous twenty (20) business day period.

13.7.1.10

CHS-LA will provide DHH with a full written documentation that will include a comprehensive Corrective Action Plan (CAP) describing how CHS-LA will prevent the problem of occurring in the future. This will be provided to DHH within five (5) business days of the occurrence of a problem with system availability.

13.7.1.11

CHS-LA understands it is not responsible for the availability and performance of systems and IS infrastructure technologies outside of our span of control.

13.8 Contingency Plan

13.8.1

CHS-LA will review and amend all Contingency Plans as necessary to ensure the inclusion of both a disaster recovery plan and a business continuity plan. These plans will be available for DHH review and approval during the Readiness Review.

13.8.1.1

CHS-LA will address the scenarios offered through the following strategies:

- Computer Installation and resident software destroyed or damaged.
 - CHS-LA will utilize back up hardware to apply the latest data backup. Transaction logs would then be applied to bring this system up to date and in line to where production was at failure. If backup hardware is unavailable, CHS-LA would use existing vendor relations to procure adequate hardware.
 - System interruption or failure resulting from network,
-

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operating hardware, software, or operations error that compromise the integrity of transaction that are active in a live system at the time of the outage.

- The issue would initially be addressed by replacing applicable hardware or restoring from backup. Depending on the severity of the issue within the application, the database would either be:
 - Rolled back to a time prior to the event.
 - Restored from backup and transaction logs.
- System interruption or failure resulting from network, operating hardware, software, or operations error that compromise the integrity of data maintained in a live or archival system.
 - The severity of the issue would be investigated to determine the extent of data loss or corruption so that the appropriate recovery mechanism could be utilized.
- System interruption or failure resulting from network, operating hardware, software, or operations error that does not compromise the integrity of transaction or data maintained in a live or archival system, but does prevent access to the System, such as it causes unscheduled System unavailability.
 - The cause of the issue would be investigated and corrected as necessary. In the event of prolonged outage a roll over to back up hardware would be completed.

CHS-LA's Contingency Plan specifies projected recovery times and data loss for mission critical systems in the event of a declared disaster.

13.8.1.2

CHS-LA will annually test the Contingency Plan through:

- Simulated disasters.
- Lower level failures.

The tests will be used to demonstrate to DHH that CHS-LA has the ability to restore system functions.

13.8.1.3

If CHS-LA is unable to demonstrate, through the annual testing of the Contingency Plan, that all System functions can be restored, CHS-LA will submit a CAP to DHH that will describe how the failure shall be resolved within ten (10) business days of the conclusion of the test.

13.9 Off Site Storage and Remote Back-Up

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13.9.1

CHS-LA utilizes Peak10 for off-site storage and remote back-up of databases and servers. Our knowledge base maintains current procedures/standards, and system documentations.

13.9.2

The data back-up policy and procedures shall include, but not be limited to:

13.9.2.1

Descriptions of the controls for back-up processing, including how frequently back-ups occur:

- Database: Nightly Differential, Weekly Full
- Servers: Nightly Backup

Note: We have the capacity to backup as frequent as every 15 minutes.

13.9.2.2

Our knowledge base maintains current procedures/standards, and system documentation as well as backup schedules.

13.9.2.3

Peak 10 datacenter maintains CHS-LA's off-site backups.

13.9.2.4

CHS-LA and Peak 10 follow all HIPAA rules and policies. Peak 10 recently underwent a successful audit of HIPAA/HITECH privacy controls.

13.9.2.5

CHS-LA agrees and has the ability to produce this type of documentation.

13.9.2.6

All production jobs, schedules, databases, server and backup server software (including description) are listed in the documentation.

13.9.2.7

CHS-LA has policies in place to insure that technology changes have change impact conducted to determine any downstream effect on backup and recovery. In the event a change is required it will follow our change request (CR) process.

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13.9.3

CHS-LA can and will provide DHH with a quarterly list of all back-up files stored at remote locations and the frequency with which these files are updated.

13.10 System User and Technical Support Requirements

13.10.1

Help Desk services will be provided by CHS-LA to all entities that have direct access to the systems within CHS-LA's direct control.

13.10.2

CHS-LA's Help Desk will provide the following:

- CHS-LA's Help Desk personnel will be available via toll-free telephone number and email between the hours of 7a.m and 7p.m CT Monday through Friday to support DHH and other authorized users. Upon request by DHH, CHS-LA will provide Help Desk resources on a state holiday, Saturday, or Sunday.
- Help Desk personnel are trained on, and can respond to questions regarding, system functions and capabilities. When necessary, Help Desk personnel have the ability to escalate issues to the appropriate personnel, including DHH staff, via telephone transfer, through CHS-LA's Help Desk software or through another agreed upon method. Help Desk software is used to monitor recurring programmatic and operation problems by appropriate personnel.
- Help Desk personnel will respond to callers who leave messages after the hours of 7a.m through 7p.m Monday through Friday by noon the next business day.
- Help Desk personnel shall document all recurring issues in issue tracking software and report said deficiencies to CHS-LA's management within one (1) business day of recognition.
- CHS-LA utilizes Kayako Resolve Help Desk Software, a comprehensive help desk and ticket management solution. The software has the ability to utilize web and email points of contact and an intelligent ticket routing and filtering mechanism and automatic service level escalation.

13.11 System Testing and Change Management Requirements

13.11.1

CHS-LA will notify DHH staff of changes to the system within at least ninety (90) calendar days of the projected date of change. This is easily

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implemented by establishing a communication channel to DHH from CHS-LA's Change Control Board (CCB).

Change Control Board (CCB):

- CCB is made up of representatives from the business and the IT teams.
- CCB reviews all requests and determines if the change needs to be made.
- If the change is rejected, it falls out of further processing and its status is set to Denied.
- If the change is accepted, it is prioritized with all other open change requests.
- CCB identifies the requests to be included in the release.

13.11.1.1

Notification to DHH from the CCB will occur when upgrades, modifications, conversions or updates are made to the following core systems:

- Claims pre-processing.
- Medicaid recipient eligibility verification processing.
- Service authorization management.
- Provider file and data management.

13.11.1.2

Upon notification from DHH of system problems that do not result in system unavailability, CHS-LA will respond to the DHH notification based upon the following timeframes:

- Written response within five (5) calendar days.
- Correction made or a requirements analysis and document will be completed and delivered to DHH within fifteen (15) calendar days.
- CHS-LA will correct any deficiency by an effective date determined by DHH.

CHS-LA utilizes Visual Source Safe a tool developed by Microsoft used for source code version control.

CHS-LA's system utilizes access management functions that restrict user access at various levels safeguarding against unauthorized modification in core systems.

13.11.1.3

In order not to compromise critical business operations, CHS-LA unless otherwise agreed upon in advance with DHH will not schedule system unavailability during business hours for:

- System maintenance.
-

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- System repair.
- System upgrade.

13.11.1.4

CHS-LA will work with DHH or other authorized entity on testing initiatives and will provide system access sufficient to allow for testing by DHH and/or its FI during the on-site readiness review.

13.12 Information Systems Documentation Requirements

13.12.1.1

CHS-LA will develop system process and procedure manuals specific to DHH that document all manual and automated processes.

13.12.1.2

CHS-LA will develop, prepare, print, produce, maintain, and distribute system documentation to DHH in an agreed upon format including:

- Management manuals.
- User manuals.
- Quick reference guides.
- Update/upgrade documentation.

13.12.1.3

All user manuals will contain information about, and instruction for, using applicable system functions and accessing applicable system data.

13.12.1.4

For system changes requiring DHH approval, CHS-LA will provide DHH updated system documentation of changes prior to implementing the changes.

13.12.1.5

Ensure all manuals and reference guides are available in printed form and/or on-line.

13.12.1.6

Electronic versions of all manuals will be updated immediately. Print versions of manuals will be updated within ten (10) business days.

13.13 System Function Reporting Requirements

CHS-LA has the system capabilities and ad-hoc reporting tools that will enable DHH, FI or other DHH authorized staff or contractors, and designated Louisiana Attorney General Office staff secured views, with associated authorization making data available for ad-hoc reporting. Example to such tools would be SQL Server Management Studio and

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our SSRS ad-hoc reports.

13.14 Electronic Messaging

CHS-LA shall provide an e-mail link to facilitate communication with DHH. By policy, no Protected Health Information (PHI) or confidential data, encrypted or secured by other means, is sent via email outside of the organization. To facilitate the transfer of this PHI/confidential data a secure FTP server (SFTP) is in place. We require a user name and password, as well as public/private key pair to connect to the SFTP site. Each entity connecting to our SFTP site must have their own unique public/private key pair, and are assigned unique user names and passwords.

13.15 Address Standardization

The system uses mailing address standards in accordance with the United States Postal Services. The standards applied include, but are not limited to:

- Standardized delivery address line and last line
- Zip + 4
- City verification for Zip code
- Secondary address unit designators
- Common designators such as:
 - APT = Apartment
 - BLDG = Building
 - FLR = Floor

13.16 Electronic Medical Records

At such time that DHH requires, CHS-LA shall participate and cooperate with DHH to implement a secure accessible health record for members, such as a Personal Health Record (PHR) or Electronic Health Record (EHR). CHS-LA already has a project underway looking into this in order to complement our current Electronic Medical Record.

13.17 Statewide Health Information Exchange

At such time that DHH requires, CHS-LA shall participate in statewide efforts to incorporate all hospital, physician and other provider information into a statewide health information exchange.

13.18 HIPAA-Based Formatting Standards

The CHS-LA system follows HIPAA-compliant standards for information exchange. Transaction types supported include but are not limited to:

- ASC X12N 834 Benefit Enrollment and Maintenance.

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- 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.
- ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products.

13.19 Audit Requirements

13.19.1 State Audit

CHS-LA, upon written request, will provide to state auditors (to include legislative auditors) files for any specified accounting period that a valid Contract exists. File formats will be compatible with DHH and/or state auditor facilities. CHS-LA will assist the state auditor in processing or utilizing the files.

In the event that the state auditors find discrepancies or errors, CHS-LA will provide a written CAP to DHH within ten (10) business days of receipt of the audit report.

At the conclusion of the audit, CHS-LA will participate in an exit interview with the state auditors. The finding will be reviewed by DHH and integrated into CHS-LA's Electronic Data Processing (EDP) manual.

13.19.2 Independent Audit

13.19.2.1

CHS-LA will subcontract with an experienced independent firm (approved by DHH) to conduct EDP and compliance audits in accordance with applicable federal and state auditing standards for applications comparable with the scope of the Contract's System application. The independent audit firm will:

- Perform limited scope EDP audits on an ongoing and annual basis. The audits will be based on DHH's audit program specifications. Audits will be performed at:
 - The conclusion of the first twelve (12) month period.
 - Each twelve (12) month period thereafter while the contract is in force.
- Perform a comprehensive audit annually to validate CHS-LA's compliance with the obligations specified in the RFP.

13.19.2.2

The auditing firm will provide to CHS-LA and DHH a report of

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findings including recommendations within thirty (30) calendar days of the close of the audit. The report provided will be in accordance with generally accepted auditing standards for EDP application reviews.

13.19.2.3

CHS-LA understands that DHH will use the findings and recommendations of each report as part of its monitoring process.

13.19.2.4

At the conclusion of the audit, CHS-LA will participate in an exit interview with the audit. The findings will be reviewed by DHH and integrated into CHS-LA's Electronic Data Processing (EDP) manual.

13.19.2.5

The audits performed will include a scope necessary to fully comply with AICPA Professional Standards for Reporting on the Processing of Transactions by Service Organizations (SAS-70 Report).

13.20 System Refresh Plan

Part of CHS-LA strategic planning involves an annual review and assessment of the need to:

- Modify, upgrade and/or replace application software.
- Modify, upgrade and/or replace operating hardware and software.
- Modify, upgrade and/or replace telecommunications capabilities.
- Modify information management policies and procedures.
- Modify systems management policies and procedures.

The review is focused on items such as:

- Changes to business requirements.
- Technology obsolescence.
- Staff turnover.

System requirements as well as any planned upgrades are verified against the system requirements for the entire operating platform. This information can be formatted to DHH specifications and can be available for review by DHH.

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Section Q: **Information Systems (Section 13 of RFP)**

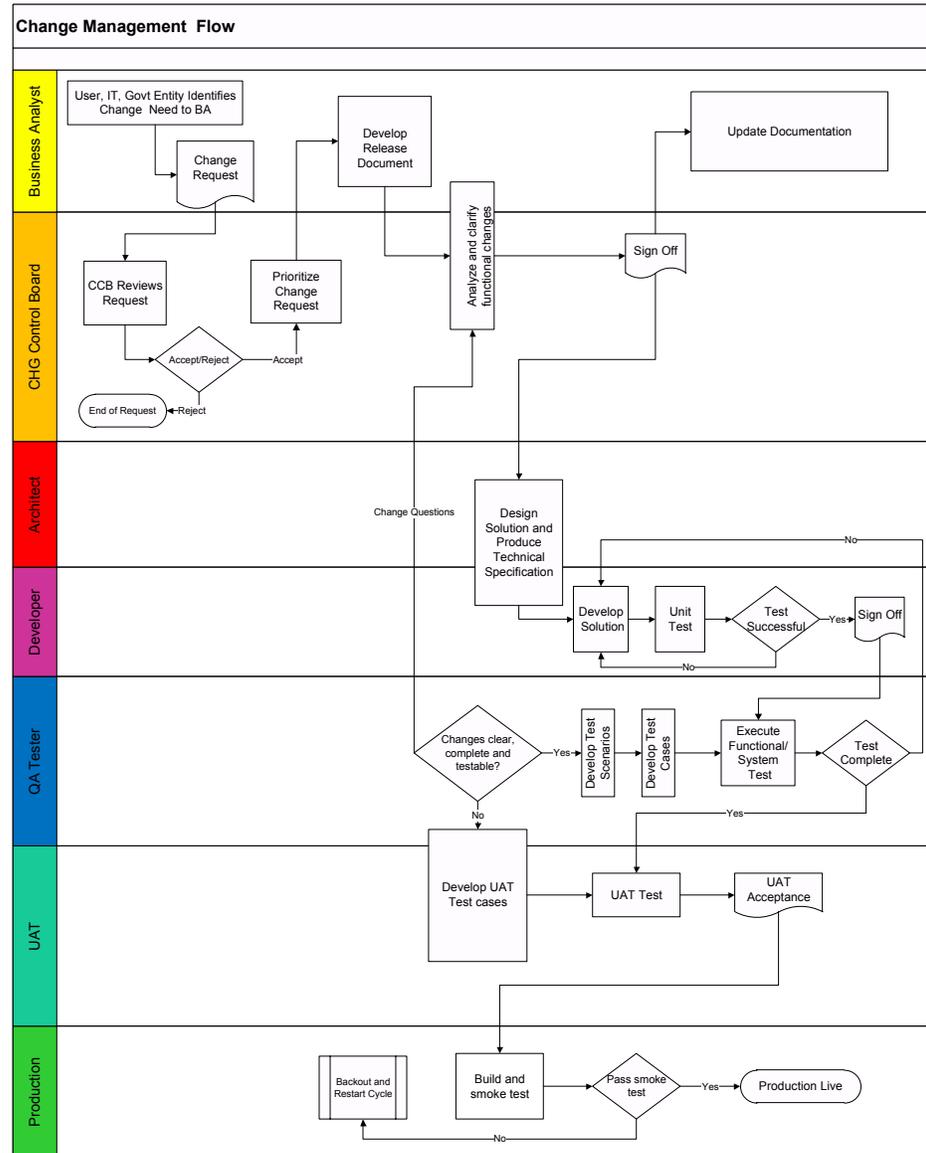
Requirement Q.8: *Describe your information systems change management and version control processes. In your description address your production control operations.*

Response: Community Health Solutions of Louisiana’s (CHS-LA) information systems change management and version control differs slightly between applications from infrastructure. Each is described below.

Application Change Management

Application Change Management is controlled by a process which includes all players in the application development lifecycle. Each release is assigned a number which is an indicator of the impact on the system. An example of a release number is 1.2.3 where 1 is a major release affecting database and major server and front end changes, 2 represents an application enhancement to functionality and 3 represents minor fixes and modifications.

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Business Analyst (BA):

- BA receives the change from the user, IT or government entities and logs it for discussion with the Change Control Board.
- BA documents initial impact review.
- BA generates Release Document to identify all changes bundled in the release.
- BA provides further analysis and documents full impact of changes in the release.
- BA modifies user documentation prior to release.

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Change Control Board (CCB)

- CCB is made up of representatives from the business and IT teams.
- CCB reviews all requests and determines if the change needs to be made.
 - If the change is rejected, it falls out of further processing and its status is set to Denied.
 - If the change is accepted, it is prioritized with all other open change requests.
- CCB identifies the requests to be included in the release.

Architects

- The architects define the overall application architecture (i.e. security, database, interface, and communications).
- Architects resolve high-level functional issues.
- Architects coach the software engineering team in the development of the solution.
- Architects provide continuity in all major application solution decisions.

Development Team (DT)

- DT codes the application based on the functional specification.
- DT unit tests all application changes.

Quality Assurance Team (QA)

- QA reviews requirements to ensure all change requests are clearly defined and testable.
- QA creates documentation that outlines the testing portion of the System Development Life Cycle.
- QA develops test cases that meet the business and technical requirements determined from requirements gathering and system design. When applicable, test cases are re-used to test functionality when new code is introduced.
- QA performs test execution by running each test case or set of conditions in the application itself. The result of the test is determined by comparing the actual results to the expected results.
 - Failure to meet expected functionality results in defect creation and management. The system does not move into production if there are Critical or High defects.
 - User Acceptance Test (UAT) test cases are designed to represent real business scenarios and functions relevant to the end-users (business users).
 - UAT is the final step before business sign-off and

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implementation of the application into production. UAT helps find defects related to the usability of the application and ensures that the applications meet the functional requirements set forth in the business analysis phase.

- UAT Acceptance is an indication that the product is ready to be delivered to business' satisfaction and expectations.

Visual Source Safe 2005

- Visual Source Safe is a standard Microsoft tool we use for source code version control.

Production

- Once the build is in production a "smoke test" is performed. The smoke test is a non-invasive test that will ensure all system functions are running correctly (i.e. Phone Integration, Fax Integration, Database Connectivity, Installation, etc.).
 - If the smoke test passes we are considered live in production and the results are communicated to the appropriate parties.
 - If the smoke test fails, standard, pre-planned back-out procedures are implemented to roll production back to (the way it was before the update). The results are communicated to the appropriate parties, and the development and test cycles are resumed to address the issue causing failure.

Infrastructure Change Management

CHS-LA uses a 3-tier approach to update and maintain the operating environment.

A. Development Server

1. Notify ALL stake holders of the pending updates and schedule.
 2. Read and review ALL notes on any Windows Updates/hotfixes.
 3. Segregate out any updates/hotfixes that do not need to be applied.
 4. Backup all development/database work on server.
 5. Apply ALL security updates first, reboot server.
 6. Apply ALL hotfixes and application specific updates and reboot, if needed.
 7. Notify all stake holders that the updates/fixes have been applied.
 8. Over a 1 week period, test the system to see if there are any
-

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issues.

9. Correct any issue(s), if any. Repeat testing of system. If testing results in complete failure, rollback.
10. Move to QA if process completes without issue.

B. QA Server

1. Notify ALL stake holders of the pending updates and schedule.
2. Read and review ALL notes on any Windows Updates/hotfixes.
3. Segregate out any updates/hotfixes that do not need to be applied.
4. Backup all databases/Reports work on server.
5. Apply ALL security updates first, reboot server.
6. Apply ALL hotfixes and application specific updates and reboot, if needed.
7. Notify all stake holders that the updates/fixes have been applied.
8. Over a 1 week period, test the system to see if there are any issues.
9. Correct any issue(s), if any. Repeat testing of system. If testing results in complete failure, rollback.
10. Move to Production if process completes without issue.

C. Production Server

1. Notify ALL stake holders of the pending updates and schedule.
2. Read and review ALL notes on any Windows Updates/hotfixes.
3. Segregate out any updates/hotfixes that do not need to be applied.
4. Backup all Production databases/FileStream folders on Server.
5. Apply ALL security updates first, reboot server.
6. Apply ALL hotfixes and application specific updates and reboot, if needed.
7. Notify all stake holders that the updates/fixes have been applied.
8. Over a 1 week period, test the system to see if there are any issues.
9. Correct any issue(s), if any. Repeat testing of system. [At this stage, ONLY if a major failure, then roll-back until a solution can be determined]

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Section Q: **Information Systems (Section 13 of RFP)**

Requirement Q.9: *Describe your approach to demonstrating the readiness of your Management Information systems to DHH prior to the start date of operations. At a minimum your description must address:*

- *provider contract loads and associated business rules;*
- *eligibility/enrollment data loads and associated business rules; and*
- *claims processing and adjudication logic.*

Response: Community Health Solutions of Louisiana’s (CHS-LA) approach to demonstrating the readiness of our Management Information Systems (MIS) to DHH, prior to the start date of operations, is consistent across projects, regardless of whether the project is associated with a new or existing client. It involves management, preparation, execution and reporting (results).

Management

Due to the size of this project, we are proposing that a Project Office be established that can facilitate the communication and coordination among internal and external entities. We believe that readiness is not demonstrated through a one-time event, but, rather, through successful achievement of a series of milestones. Through this process, DHH will gain confidence in our ability to not only meet, but exceed expectations and will gain comfort in developing a partnership with CHS-LA. In addition, we believe a Readiness Review Board (RRB) should be established to make the final “go/no go” decision. We believe that this board should be comprised of key stakeholder from both DHH and CHS-LA and contain business area and Information System (IS) team representatives.

Preparation and Execution

Readiness, from a preparation and execution perspective, would follow a normal project lifecycle. Based upon business application and infrastructure requirements approved by DHH, CHS-LA will build test plan(s) and test cases. It is assumed that many of these will involve modifications to existing internal and client plans which relate to the same care model. To confirm this process is complete, a traceability matrix is required between requirements and test cases. This would be required prior to test execution.

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The results from test execution would be logged within the test plan and available at the time of Readiness Review. At any time, detailed test results can also be reviewed for completeness.

Reporting

Not all failures coming out of the testing effort constitute a failure of readiness, thus they will need to be assessed. All failures would be routed to the RRB to assess effect, risks and possible mitigation.

The RRB will also have access to the Issue/Risks Tracking database for review of any outstanding issues/risks. It is assumed that issues/risks may constitute a “no go” decision, even though the test plans have passed.

Lastly, in support of readiness from an IS perspective, an additional model office environment will be set up to mirror production. This will provide two environments (UAT/QA, Model Office) for readiness acceptance testing.

Specific interfaces and business edit requirements requested within this question

Based on CHS-LA tools to parse data (EDI standards) and/or use transformation tools, no data files will create issues. The key approach to readiness in this area is well defined definitions, test preparation, test execution and reporting results to all stakeholders.

Provider contract loads and associated business rules:

Provider

- Duplicate NPI number verification - Verify the provider name in the file matches the name associated with the NPI number in the system. If not a match prints on error report for review.
- Required field verification - Verifies all fields from file layout that are required to determine claims payment are populated with valid data. If required field is missing, prints on error report for review.
- Address verification - Verifies and corrects address abbreviations, punctuations and structure per USPS standards.

Eligibility/enrollment data loads and associated business rules: HIPAA 834

HIPAA Parser

- HIPAA required transaction set validation - Verifies all required transactions sets.
-

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- HIPAA transactions set value validation - Verifies accepted transaction set values.
- 997 - Functional Acknowledgment sent.

Eligibility File Load from Parser into ECD System

- Duplicate SSN validation - Verifies SSN is not associated with a different Medicaid ID. If duplicate found prints on error report for review.
- Duplicate Name/DOB validation - Import process does a first name, last name and DOB search and verifies Medicaid ID. If match is found with different Medicaid ID prints on error report for review.
- Address validation - Verifies and corrects address abbreviations, punctuations and structure per USPS standards.
- Medical Home validation - Verifies member is enrolled with an active contracted Medical Home. If invalid Medical Home prints on error report for review.
- Member enrollment validation - New, previous or current enrollment record type. The following will print on error report for review.
 - Enrollment date received same as system enrollment date with different Medical Home.
 - Enrollment date received prior to system enrollment date.
 - Enrollment date received same as system enrollment date and system shows disenrollment date.
 - New enrollment date received, different from system enrollment date with no previous disenrollment date.
- Member disenrollment validation - Disenrollment record type. The following will print on error report for review.
 - Disenrollment received with same enrollment date and Medical Home as system. System shows previously disenrolled.
 - Disenrollment received with no enrollment record received.
 - Disenrollment received for Medical Home not in member record.
 - Disenrollment received with no system matching enrollment date.

PMPM Payment/Remittance File from State - HIPAA 820

HIPAA Parser

- HIPAA required transaction set validation - Verifies all required transactions sets.
 - HIPAA transactions set value validation - Verifies accepted transaction set values.
-

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- 997 – Functional Acknowledgment sent.

Payment/Remittance File Load from Parser into System

- Payment amount and payment month loaded into member record. Debit adjustment records will print on adjustment report for coverage review.
- Missing Member report – Reports active members that no payment record was received and no disenrollment record was received.
- Premium Verification report – Reports members who were enrolled with retroactive enrollment dates and payment record was not received for each month.

Claims processing and adjudication logic

Paper Claims Process into System – Scan OCR

- Claims are scanned and given image document numbers.
- Claims are scrubbed through OCR to verify all fields are importing correctly.
- Claims file is imported into the System.

Electronic Claims (837P, 837I) Process into System through HIPAA Parser

- HIPAA required transaction set validation – Verifies all required transactions sets.
- HIPAA transactions set value validation – Verifies accepted transaction set values.
- 997 – Functional Acknowledgment sent.

ECD System Processing

- Claim is matched to member using member Medicaid ID. If no member is found claim is rejected and HIPAA 277 Claims Status is sent for electronic claims and letter sent for paper claims.
 - Billing/Pay to provider is linked to claim using the previously loaded provider file. If no match claim is sent to workflow for review.
 - Servicing provider is linked to claim using the previously loaded provider file. If no match claim is sent to workflow for review.
 - Timely filing validation – If the claim is not received within the state specified time frame, the claim is denied.
 - Duplicate claim validation – If claim is an exact duplicate the system will deny the claim. If it is a possible duplicate claim is sent to workflow for review.
-

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- Claims edit validation – Verifies bill coding using Ingenix Claims Edit guidelines.
 - Invalid, deleted or unlisted CPT/HCPCS code – Claim is denied.
 - CPT/HCPCS code has a bilateral indicator - System will verify there is a valid bilateral modifier. If no valid modifier, the claim is sent to workflow for review.
 - CPT/HCPCS code has a digit indicator - System will verify there is a valid digit modifier. If no valid modifier, the claim is sent to workflow for review.
 - Anesthesia CPT/HCPCS code not performed by CRNA or anesthesiologist – Claim is denied.
 - Surgery CPT/HCPCS code with ANES modifier - Claim is flagged for review or original line denied and new line created with appropriate Anesthesia code. This is determined by client setting.
 - Multiple anesthesia procedures – Only primary anesthesia code is allowed, all additional anesthesia procedures are denied.
 - Claim is analyzed for bundling or unbundling of charges – Claim is recoded per claims edit criteria or claim is sent to workflow for review. This is determined by client setting.
 - Claim is analyzed multiple surgical procedure reduction – Payment calculation will be reduced based on client setting.
 - CPT/HCPCS is analyzed for valid place of service – If invalid charge will be denied.
 - CPT/HCPCS is analyzed for valid modifier 26 usage – If invalid charge will be denied.
 - CPT/HCPCS is analyzed for appropriate gender – If invalid charge will be denied.
 - CPT/HCPCS is analyzed for appropriate age – If invalid charge will be denied.
 - CPT/HCPCS is analyzed for appropriate frequency per day – If invalid charge will be denied.
 - CPT/HCPCS is analyzed for follow-up days within a global surgical package – If invalid charge will be denied.
 - Modifier validation – If modifier is not appropriate for procedure code, the claim is sent to workflow for review.
 - Invalid, deleted or unlisted ICD-9 code – Claim is denied.
 - ICD-9 validation – If ICD-9 is not appropriate for procedure code, the claim is sent to workflow for review.
 - ICD-9 is analyzed for appropriate gender – If invalid, the charge will be denied.
 - ICD-9 is analyzed for appropriate age – If invalid, the charge will be denied.

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- Referral number validation - If service/provider requires a referral number, the system will match the referrals received for the member using the date of service and servicing provider NPI. If no referral found, the claim is sent to workflow for review.
- Precertification validation - If service requires precertification, the system will match precertification's received for the member using the service type and the dates of service. If no precertification is found, the claim is sent to workflow for review.
- Form validation - If service requires a specific state form, the system will verify that a form attachment has been received with the claim. If form is received, the claim is sent to workflow for review. If no form is received, the claim is denied.
- State specified billing requirements validation - The system will verify all state specified billing requirements have been met for the service rendered. If not met, the claim is denied.
- Visit limit validation - The system will verify that any applicable visit limit has not been met using the member visit accumulators. If met, the claim is denied. If not met, the visit accumulator is updated.
- Fee Schedule applied to claim - The program required fee schedule will be applied to claim.
- Pre-processing finalized.

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Section Q: **Information Systems (Section 13 of RFP)**

Requirement Q.10: *Describe your reporting and data analytic capabilities including:*

- *generation and provision to DHH of the management reports prescribed in the RFP;*
- *generation and provision to the State of reports on request;*
- *the ability in a secure, inquiry-only environment for authorized DHH staff to create and/or generate reports out of your systems on an ad-hoc basis; and*
- *Reporting back to providers within the network.*

Response:

Community Health Solutions of Louisiana (CHS-LA) possesses robust reporting and data analytic capabilities. Reports generated from within the transactional system are operational reports identifying point in time conditions for managerial review and intervention, if needed. Additionally, the data warehouse provides information over time (daily, weekly, monthly, and on demand) including tracking and trending capability.

CHS-LA currently produces all reports indicated in the RFP. In the event that the current format differs then what is required by DHH, CHS-LA will make the appropriate modifications.

Examples of current reports we provide that match the RFP request are:

- Number of members identified with potential special healthcare needs utilizing historical claims data.
- Number of members with special healthcare needs identified by the member's PCP.
- Number of identified members with assessments.
- Number of members with assessments resulting in a referral for Care Management.
- Number of treatment Care Plans completed.
- GeoAccess maps and reports to demonstrate access and availability of network providers. These reports can include all provider types or be limited to one, or more, provider types such as:
 - primary care providers
 - specialty care providers
 - hospitals
 - ancillary providers

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- Specialist referrals by PCP.
- Emergency department utilization by PCP.
- Hospital admissions by PCP.

Other examples of data available through the data warehouse are:

- Total number of members.
- Number of members in each stratification (acuity) level for each chronic or complex condition. Number of members who were disenrolled from the program, with accompanying explanation of basis for disenrollment.
- Number of educational sessions a member participated in and accompanying impact on acuity level.
- Report of all claims paid in the prior month for services rendered.
- Report of all claims paid in the prior month for services rendered, other than PCP rendered services, that have an associated referral number.

Reports on request are developed by a team of 'on demand' report writers.

CHS-LA will develop specific reporting once the state has identified its requirements and the contract has been awarded. These reports will be developed from our current reports and augmented for state specific requirements.

Secured views, with associated authorization, will make data available for DHH staff users of ad hoc reporting. View of Protected Health Information (PHI) or confidential data contained within the reports is controlled by Active Directory roles. Users are tied to roles and roles are tied to the reports or data that can be accessed.

Data warehouse reports are delivered via a secure website authenticated by Active Directory. In addition, security controls specific Users authorization to specific reports.

External reports are reported back to the providers and other external entities via the Document Distribution System (DDS) through secure FTP site.

The reporting solution is delivered through the Microsoft Suite of products; specifically Sql Server Reporting Services (SSRS) and Sql Server Integration Services (SSIS).

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Section Q: **Information Systems (Section 13 of RFP)**

Requirement Q.11: *Provide a detailed profile of the key information systems within your span of control.*

Response: The following list details applications within Community Health Solutions of Louisiana’s (CHS-LA) Information Systems (IS) span of control. Supplementing the list is a brief description and technology for each system.

Application	Abbr
Consensus Care Management	CCM
Data Warehouse	DWH
Document Distribution System	DDS
Enrollment/Claims Data System	ECD
Forte Gate	Package *
GeoAccess	Package *
HEDI Parser	HPS
Incident Tracking System	Package *
InContact Telephony System	Outsource **
iSynergy Document Management	Package *
Microsoft Business Contact Manager	Package *
Microsoft Infopath	Package *
Microsoft Office 2010	Package *
Microsoft Visual Safe	Package *
Payment Disbursement System	PDS
Primary Caregiver Transfer Request System	PCTR
Provider Contracting System	PCRS
Provider Credentialing System	PCS
Quality Incident Referral	QIR
Kayako Resolve Helpdesk	Package *

* Indicates software installed and performing on CHS hardware
 ** Indicates software installed and performing on vendor hardware

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Consensus Care Management

Abbreviation: CCM

Business Area: Care Management

Brief Description: Consensus Care Management (CCM) is the state of art system that drives and captures activities in both the Case Management and Utilization Management arenas. CCM is a patient centric tool that builds an electronic medical record from multiple information sources allowing the most at-risk patients to be effectively managed. Case management staff supports patients by using the many tools available to them such as: health risk and disease specific assessments, mental health assessments, disease self-managing educations, maternity and newborn and infant self-managing education as well as the ability to develop evidence based care plans. Utilization Management staff use the system to provide certifications for medically appropriate requests, track unlimited concurrent requests and tracks timings to meet all standards. The system provides 'follow up' reminders to monitor patients while in acute care facilities and provide outpatient response in a timely manner.

Technology: .Net 4.0, SQL Server 2008 R2, IIS, 3 tiered SOA

Data Warehouse

Abbreviation: DWH

Business Area: Shared Service

Brief Description: The data warehouse is our repository for reporting, transforming and sharing operational data bidirectionally.

Technology: SQL Server 2008 R2, SQL Server Reporting Services (SSRS) and SQL Server Integration Services (SSIS)

Document Distribution System

Abbreviation: DDS

Business Area: Shared Service

Brief Description: Document Distribution System delivers information in terms of reports and files to and from external sources. It utilizes HIPPA compliant secure FTP and obfuscates the file names and file locations.

Technology: PHP, HTML, IIS, MySQL

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Enrollment/Claims Data System

Abbreviation: ECD

Business Area: TPA

Brief Description: The enrollment side of ECD tracks and identifies numerous data elements on the membership of the program. Data on enrollment and disenrollment, including items such as:

- Effective dates.
- Termination dates.
- Disenrollment reasons.
- Type of disenrollment.
- Demographic information.

Historical data is maintained for auditing and legislative compliance purposes.

The claims side of ECD is used to collect, process and store encounter/claims data on all health and medical services delivered to our members. It uses benefit rules such as visit limitations and service authorization requirements unique to each client. System edits such as date validation and eligibility validation based service date are performed. The system supports all industry standard codes such as:

- CPT/HCPCS
- ICD-9 (future ICD-10)
- Revenue Codes
- HCPCS Level II
- CPT Category II

The system integrates with the Ingenix Claims Edit Knowledge Base to automatically detect such items as:

- Coding errors related to unbundling
- Modifier appropriateness
- Mutually exclusive and incidental procedures

Technology: Windows based application through Revelation Development Software platform (Open Insight 9.2).

ForteGate

Abbreviation: N/A

Business Area: Shared Service

Brief Description: ForteGate consolidated security platform delivers all of our network security requirements such as:

- Firewall, VPN, and Traffic Shaping.
- Intrusion Prevention (IPS).
- Antivirus/Antispyware/Antimalware.

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- Application Control.
- Web Filtering.
- Antispam.
- WAN Optimization & Web Caching.

Technology: Package

Geo Access Mapping

Abbreviation: N/A

Business Area: Shared Service

Brief Description: Geographic data, such as that from the Provider Subsystem produces Geo Access maps and reports to demonstrate access availability of network providers supporting the program. These reports can show items such as Primary Care Providers, specialists, hospitals, and ancillaries. This tool gives the ability to add precision to accessibility analysis and deeper insight about the network.

Technology: Package

HEDI Parser

Abbreviation: HPS

Business Area: TPA

Brief Description: This specialized module is used for processing all HIPAA-related transfers. The process includes the receipt, logging, validation of required fields, translation and integration of all data elements into (ECD).

Technology: Microsoft Visual Basic

Incident Tracking System

Abbreviation: N/A

Business Area: Shared Service

Brief Description: The Incident Tracking System manages communication of software bugs and enhancements through the development process.

Technology: Package

InContact Telephony System

Abbreviation: N/A

Business Area: Shared Service

Brief Description: The Telephony system covers all internal as well as call centers and utilizes a scalable hosted VOIP solution and includes

Community Health Solutions of Louisiana (CHS-LA)

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fully customizable IVR and ACD functionality. The system records all calls and includes full reporting capabilities to analyze call volumes, call types, conversation times, hold times, queue counts, abandonment rates, etc. Live monitoring tools allow for supervisors to track current workload utilization, queue volumes, wait times, and service levels. Our vendor maintains 7x24x365 SAS 70 certified data centers and guarantees 99.99% availability.

Technology: Package

iSynergy Document Management

Abbreviation: N/A

Business Area: Shared Service

Brief Description: iSynergy is an integrated information management software solution combining functions such as:

- Document and data capture.
- Process automation.
- Workflow.
- Secure access in a single, browser-based application.

Documents and data are dynamically organized and delivered through an intuitive interface developed as needed using a customized hierarchical indexing structure designed for flexible document and data search and retrieval. This enables us to:

- Innovate business operations.
- Increase productivity.
- Share information.

Technology: Package

Microsoft Business Contact Manager

Abbreviation: N/A

Business Area: TPA

Brief Description: Microsoft Business Contact Manager allows us to manage our providers and perform lead tracking

Technology: Package

Microsoft Infopath

Abbreviation: N/A

Business Area: Shared Service

Brief Description: Microsoft Office InfoPath is a software application for designing, distributing and filling electronic forms.

Technology: Package

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Geographic Service Area: A, B, C

Microsoft Office 2010

Abbreviation: N/A

Business Area: Shared Service

Brief Description: Microsoft Office 2010 is the latest in a suite of integrated business applications. We extensively use Microsoft Word, Microsoft Excel, Microsoft Access, Microsoft Outlook, Microsoft PowerPoint, Microsoft OneNote and Microsoft Visio

Technology: Package

Microsoft Visual Safe

Abbreviation: N/A

Business Area: Shared Service

Brief Description: Microsoft Visual Source Safe is our source control management system.

Technology: Package

Payment Disbursement System

Abbreviation: PDS

Business Area: TPA

Brief Description: The Payment Distribution System (PDS) uses data from the Enrollment/Claims Data System (ECD) and the Provider Contracting System (PCRS) to calculate and produce payments for things such as providers for PMPM, Shared Savings and Claims.

Technology: Windows based application through Revelation Development Software platform (Open Insight 9.2).

Primary Caregiver Transfer Request System

Abbreviation: PCTR

Business Area: Care Management

Brief Description: Member Provider Services Department and Case Management Department use this system to track member requests for transfer to another Primary Care Providers.

Technology: Microsoft Access

Provider Contracting System

Abbreviation: PCRS

Business Area: TPA

Brief Description: The Provider Contracting System (PCRS) tracks numerous data fields for each provider including:

- Network Participation

Community Health Solutions of Louisiana (CHS-LA)

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Geographic Service Area: A, B, C

- Specialties
- Admission Privileges
- Demographics
- Languages Spoken
- Office Hours

The system supports provider numbering formats such as:

- UPIN
- NPIN
- CLIA

The system has the ability to incorporate third party data files and verify, translate and process these files prior to the incorporation to the database to maintain overall integrity and quality to the data.

Technology: Windows based application through Revelation Development Software platform (Open Insight 9.2).

Provider Credentialing System

Abbreviation: PCS

Business Area: TPA

Brief Description: The Provider Credentialing System (PCS) stores and manages provider credentialing information. Credentialing data tracked includes:

- Valid licensure
- Hospital privileges
- Valid Drug Enforcement Agency (DEA) or controlled Dangerous Substance (CDS) certificate
- Appropriate education and training
- Board certification
- Appropriate work history
- Malpractice insurance

Technology: Windows based application through Revelation Development Software platform (Open Insight 9.2).

Quality Incident Referral

Abbreviation: QIR

Business Area: Care Management

Brief Description: The QIR Module captures all quality incidents with the associated parties' demographics. The Quality Module allows easy capture of information with data assist, then hides the incident and exports it to a stand-alone system for inquiry, resolution and quality reporting.

Technology: .Net 4.0, SQL Server 2008 R2, IIS, 3 tiered SOA and Microsoft Access for standalone processes and reporting

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Geographic Service Area: A, B, C

Kayako Resolve Helpdesk

Abbreviation: N/A

Business Area: Shared Service

Brief Description: Manages user helpdesk processes. This package allows users to submit tickets via e-mail or the web interface. It comes with automated response when a ticket is received and e-mail replies when a staff members posts anything to the system. Allows for reporting of helpdesk activities.

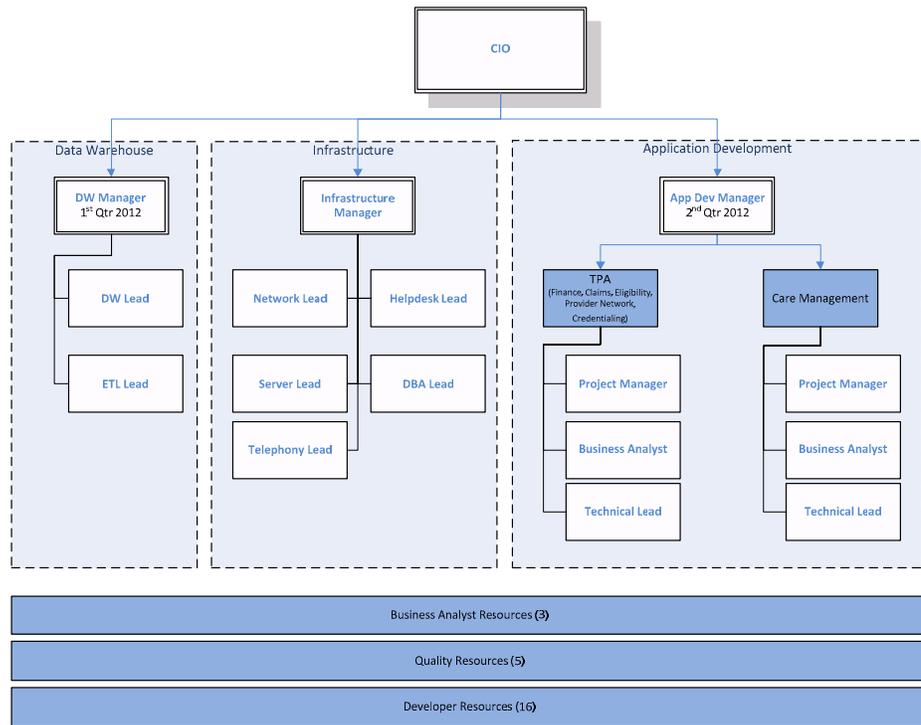
Technology: Packaged

Community Health Solutions of Louisiana (CHS-LA) CCN-S Proposal Submission Geographic Service Area: A, B, C

Section Q: Information Systems (Section 13 of RFP)

Requirement Q.12: *Provide a profile of your current and proposed Information Systems (IS) organization.*

Response: The following depicts Community Health Solutions of Louisiana’s (CHS-LA) current and near term Information Systems (IS) organizational chart. Any future resources are annotated with the expected timeframe for the requisition to be filled.



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Section Q: **Information Systems (Section 13 of RFP)**

Requirement Q.13: *Describe what you will do to promote and advance electronic claims submissions and assist providers to accept electronic funds transfers.*

Response: Community Health Solutions of Louisiana (CHS-LA) will promote and advance electronic claims submissions and offer assistance to providers in accepting electronic funds transfers through a multitude of activities, across all business areas. Specific activities include:

- The benefits of electronic claims submission and electronic funds transfers will be addressed by CHS-LA's Provider Services Representatives with providers in their initial orientation.
- CHS-LA's Information Systems area will provide, to CHS-LA's Claims area, monthly reports that identify, based on claims submissions, those providers who are still submitting claims manually.
- CHS-LA's Claims area will provide, to Provider Services Representatives and Provider Call Center staff, a monthly report, that identifies those providers who are not submitting claims or receiving funds electronically.
- For those providers identified, CHS-LA's Provider Services Representatives will encourage transition to electronic submission of claims and acceptance of funds during their quarterly provider visits.
- For those providers identified, CHS-LA's Provider Call Center staff will encourage transition to electronic submission of claims and acceptance of funds during their monthly provider calls.
- Provider Services Representatives and Provider Call Center staff will offer to link providers to CHS-LA's Claims staff for assistance with transition to electronic claims submission and electronic funds transfer.

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Community Health Solutions of Louisiana (CHS-LA)
CCN-S Proposal Submission
Geographic Service Area: A, B, C

Section Q: **Information Systems (Section 13 of RFP)**

Requirement Q.14: *Indicate how many years your IT organization or software vendor has supported the current or proposed information system software version you are currently operating. If your software is vendor supported, include vendor name(s), address, contact person and version(s) being used.*

Response: Below you will find a detailed listing of all systems currently being supported by Community Health Solutions of Louisiana (CHS-LA) or a software vendor, with all requested information.

Consensus Care Management

Abbreviation: CCM

Business Area: Care Management

Original Production Release: 2011 (replaced Progress released in 2001)

Current Version: 2011 (version 1.00.007)

Type of Development: Custom development

Upgrade Status: Continuous upgrades and modifications to meet customer's evolving needs.

Support Status: Supported Internally with staff augmentation by
Iceberg Solutions, LLC
1410 North Scott St. Unit # 964
Arlington, VA 22209
(703) 879-6689

Technology: .Net 4.0, SQL Server 2008 R2, IIS, 3 tiered SOA

Data Warehouse

Abbreviation: DWH

Business Area: Shared Service

Original Production Release: 2011 (replaced various TPA systems)

Current Version: 2011

Type of Development: Custom development and vendor package

Upgrade Status: Continuous upgrades and modifications to meet customer's evolving needs.

Support Status: Supported Internally with staff augmentation by
Iceberg Solutions, LLC
1410 North Scott St. Unit # 964
Arlington, VA 22209
(703) 879-6689

Technology: SQL Server 2008 R2, SQL Server Reporting Services and SQL Server Integration Services

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Geographic Service Area: A, B, C

Document Distribution System

Abbreviation: DDS

Business Area: Shared Service

Original Production Release: 2008

Current Version: 2011

Type of Development: Custom development

Upgrade Status: Continuous upgrades and modifications to meet customer's evolving needs.

Support Status: Supported Internally with staff augmentation by
Iceberg Solutions, LLC
1410 North Scott St., Unit # 964
Arlington, VA 22209
(703) 879-6689

Technology: PHP, HTML, IIS, MySQL

Enrollment/Claims Data System

Abbreviation: ECD

Business Area: TPA

Original Production Release: 1992

Current Version: 2011

Type of Development: Custom development

Upgrade Status: Continuous upgrades and modifications to meet customer's evolving needs.

Support Status: Supported Internally

Technology: Windows based application through Revelation
Development Software platform (Open Insight 9.2).

Geo Access Mapping

Abbreviation: N/A

Business Area: Shared Service

Original Production Release: 2005 (in our organization)

Current Version: GeoCoder v 3.8.0.0

GeoNetworks v 8.0.0.1

Claims Editing Knowledge Base v 20110401

Type of Development: Vendor Package

Upgrade Status: Vendor scheduled continuous improvement

Support Status: Vendor supported

Vendor: Ingenix

www.ingenix.com

Support: 800-683-8431

Sales: Phillip Jacobsen

Phillip.jacobsen@ingenix.com

801-982-3513

Technology: Package

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HEDI Parser

Abbreviation: HPS

Business Area: TPA

Original Production Release: 2000

Current Version: 2010

Type of Development: Custom development

Upgrade Status: Currently handles EDI 4010 and is currently being updated to handle EDI 5010

Support Status: Supported Internally

Technology: Microsoft Visual Basic

Incident Tracking System

Abbreviation: N/A

Business Area: Shared Service

Original Production Release: 2010 (in our organization)

Current Version: 2011

Type of Development: Customized version of the open source BugTracker.net application

Upgrade Status: Continuous upgrades and modifications to meet customer's evolving needs.

Support Status: Supported by staff augmentation from
Iceberg Solutions, LLC
1410 North Scott St., Unit # 964
Arlington, VA 22209
(703) 879-6689

Technology: Package

InContact Telephony System

Abbreviation: N/A

Business Area: Shared Service

Original Production Release: 2008 (in our organization)

Last Production Release: InContact Pro (latest version)

Type of Development: Vendor Package

Upgrade Status: Vendor scheduled continuous improvement

Support Status: Vendor supported

Vendor: InContact
7730 South Union Park Avenue, Suite 500
Salt Lake City, UT 84047
www.incontact.com
Support: 1-800-363-6177

Technology: Package

Community Health Solutions of Louisiana (CHS-LA)
CCN-S Proposal Submission
Geographic Service Area: A, B, C

iSynergy Document Management

Abbreviation: N/A

Business Area: Shared Service

Original Production Release: 2009 (in our organization)

Last Production Release: iSynergy version 3.9

Type of Development: Vendor Package with custom enhancements

Upgrade Status: Vendor scheduled continuous improvement and internal enhancements to support evolving business needs.

Support Status: Internally and Vendor supported

Vendor: iDatix Corporation

15201 Roosevelt Blvd, Suite 104

Clearwater, FL 33760

(727) 441-8228

Technology: Package

Kayako Resolve Helpdesk

Abbreviation: N/A

Business Area: Shared Service

Original Production Release: 2010 (in our organization)

Last Production Release: Kayako Resolve v 3.70.01

Type of Development: Vendor Package

Upgrade Status: Vendor scheduled continuous improvement

Support Status: Vendor supported

Vendor: Kayako Inc.

917 Lusk Street, Suite 110

Boise, ID 83706

www.kayako.com

Support: 1-888-212-2140

Technology: Package

Microsoft Business Contact Manager

Abbreviation: N/A

Business Area: Provider Relations

Original Production Release: 2010 (in our organization)

Last Production Release: 2010

Type of Development: Customizable Vendor Package

Upgrade Status: Vendor scheduled releases

Support Status: Vendor supported

Vendor: Microsoft Corporation

One Microsoft Way

Redmond, WA 98052-6399

Sales & Support: 800-426-9400

www.microsoft.com

Technology: Package

Community Health Solutions of Louisiana (CHS-LA)
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Geographic Service Area: A, B, C

Microsoft Infopath

Abbreviation: N/A

Business Area: Shared Service

Original Production Release: 2010 (in our organization)

Last Production Release: 2010

Type of Development: Customizable Vendor Package

Upgrade Status: Vendor scheduled releases

Support Status: Vendor supported

Vendor: Microsoft Corporation

One Microsoft Way

Redmond, WA 98052-6399

Sales & Support: 800-426-9400

www.microsoft.com

Technology: Package

Microsoft Office 2010

Abbreviation: N/A

Business Area: Shared Service

Original Production Release: 2010 (in our organization)

Previously used prior versions of Microsoft Office

Last Production Release: 2010

Type of Development: Vendor Package

Upgrade Status: Vendor scheduled releases

Support Status: Vendor supported

Vendor: Microsoft Corporation

One Microsoft Way

Redmond, WA 98052-6399

Sales & Support: 800-426-9400

www.microsoft.com

Technology: Package

Community Health Solutions of Louisiana (CHS-LA)
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Geographic Service Area: A, B, C

Microsoft Visual Source Safe

Abbreviation: N/A

Business Area: Shared Service

Original Production Release: 2010 (in our organization)

Current Version: Visual Source Safe 2005

Type of Development: Vendor Package

Upgrade Status: Maintenance Only (Possible upgrade to Microsoft Team Foundation Server if need arises)

Support Status: Vendor supported

Vendor: Microsoft Corporation

One Microsoft Way

Redmond, WA 98052-6399

Sales & Support: 800-426-9400

www.microsoft.com

Technology: Package

Payment Disbursement System

Abbreviation: PDS

Business Area: TPA

Original Production Release: 1992

Current Version: 2009

Type of Development: Custom development

Upgrade Status: Continuous upgrades to meet client's evolving needs

Support Status: Supported Internally

Technology: Windows based application through Revelation Development Software platform (Open Insight 9.2).

Primary Caregiver Transfer Request System

Abbreviation: PCTR

Business Area: Care Management

Original Production Release: 2010

Current Version: 2011

Type of Development: Custom development

Upgrade Status: Continuous upgrades to meet client's evolving needs

Support Status: Supported Internally

Technology: Microsoft Access

Community Health Solutions of Louisiana (CHS-LA)
CCN-S Proposal Submission
Geographic Service Area: A, B, C

Provider Contracting System

Abbreviation: PCRS

Business Area: TPA

Original Production Release: 1992

Current Version: 2006

Type of Development: Custom development

Upgrade Status: Upgrade currently in process to amplify efficiencies

Support Status: Supported Internally

Technology: Windows based application through Revelation
Development Software platform (Open Insight 9.2).

Provider Credentialing System

Abbreviation: PCS

Business Area: TPA

Original Production Release: 1992

Current Version: 2006

Type of Development: Custom development

Upgrade Status: Upgrade currently in process to amplify efficiencies

Support Status: Supported Internally

Technology: Windows based application through Revelation
Development Software platform (Open Insight 9.2).

Quality Incident Referral

Abbreviation: QIR

Business Area: Care Management

Original Production Release: 2011 (replaced Progress released in 2001)

Current Version: 2011

Type of Development: Custom development

Upgrade Status: Upgrade currently in process to better align with UM
requirements

Support Status: Supported internally with staff augmentation from
Iceberg Solutions, LLC
1410 North Scott St., Unit # 964
Arlington, VA 22209
(703) 879-6689

Technology: .Net 4.0, SQL Server 2008 R2, IIS, 3 tiered SOA and
Microsoft Access for standalone processing and reporting

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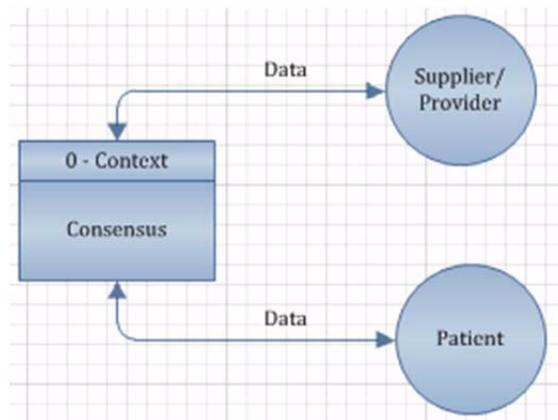
Community Health Solutions of Louisiana (CHS-LA) CCN-S Proposal Submission Geographic Service Area: A, B, C

Section Q: **Information Systems (Section 13 of RFP)**

Requirement Q.15: *Describe your plans and ability to support network providers' "meaningful use" of Electronic Health Records (EHR) and current and future IT Federal mandates. Describe your plans to utilizing ICD-10 and 5010.*

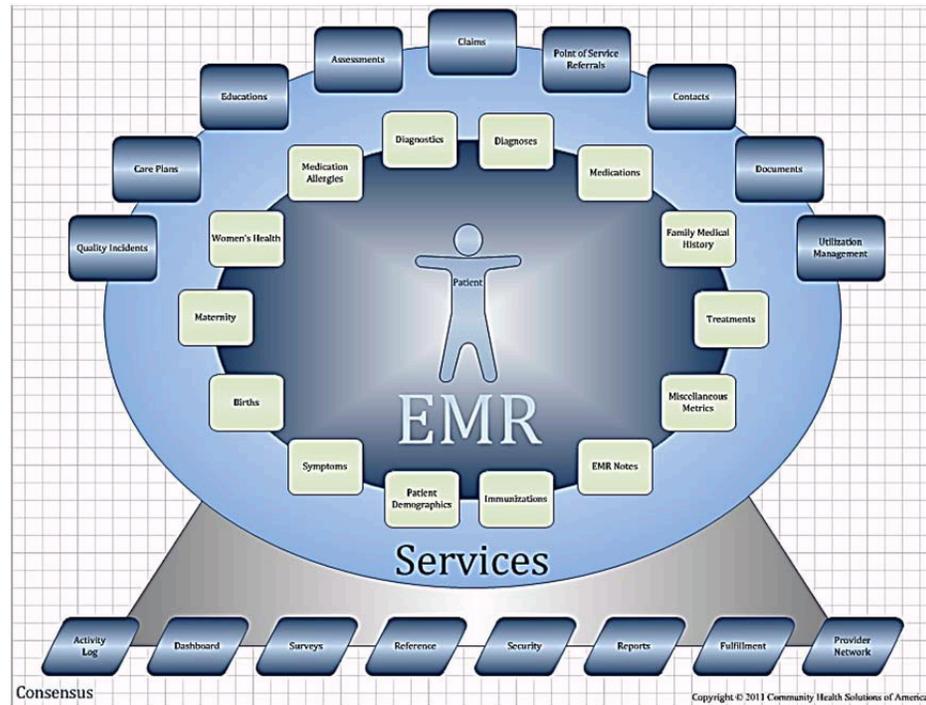
Response: Community Health Solutions of Louisiana (CHS-LA) will actively encourage PCPs to participate in the Health Information Technology (HIT) incentive programs through provider training and on-going provider communications, including information about future "meaningful use" incentive payment criteria (meaningful use Stage 2 and Stage 3), as and when finalized by the Centers for Medicare and Medicaid Services (CMS). CHS-LA will also provide links on our website to sources of information on current and future mandates, as well as tools published by CMS such as the Meaningful Use Attestation Calculator.

CHS-LA can currently support network providers with clinical data and reports from our systems on the core and menu set meaningful use criteria. Reports are provided in any appropriate format through the Document Distribution System (DDS) via secure FTP. For providers wishing to directly access their patient medical record data, CHS-LA intends to provide a provider portal.



A preliminary assessment of the Consensus system has been performed against Office of the National Coordinator (ONC) for Health IT certification testing criteria. The system currently meets many of the General and Ambulatory criteria, as well as the NQF ambulatory clinical quality measures.

Community Health Solutions of Louisiana (CHS-LA) CCN-S Proposal Submission Geographic Service Area: A, B, C



CHS-LA will be ready to support claims files submitted utilizing EDI 5010 standard and ICD-10 data files. Analysis will be required in order to ensure all new codes are added to existing systems structures, but no additional development will be required to accommodate the new file formats.

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Section Q: **Information Systems (Section 13 of RFP)**

Requirement Q.16: *Describe the procedures that will be used to protect the confidentiality of records in DHH databases, including records in databases that may be transmitted electronically via e-mail or the Internet.*

Response: Community Health Solutions of Louisiana (CHS-LA) will use the following procedures to ensure the confidentiality of records in DHH databases, including records in databases that may be transmitted electronically via email or the internet:

- Physically, all server hardware is housed in a SAS70/SSAE16 Type II datacenter. Physical access to this datacenter by internal employees is limited to greatest degree possible. Each employee must use a keycard + PIN code, as well as pass a fingerprint scan to enter the main facility. Once inside the datacenter each rack is locked with a unique combination lock.
- All production servers are protected within the firewall by our ForteGate appliances.
- By policy, no Protected Health Information (PHI) or confidential data, encrypted or secured by other means, is sent via email outside of the organization. To facilitate the transfer of PHI/confidential data, a secure FTP server (SFTP) is in place. We require a user name and password, as well as public/private key pair to connect to the SFTP site. Each entity connecting to our SFTP site must have their own unique public/private key pair, and are assigned unique user names and passwords.
- Each user by policy may only have one unique account, tied to Active Directory and re-credentialed annually. Passwords have Expiration Policy requiring reset every three (3) months. Additionally, passwords are set systematically to strong/complex through a domain group policy. Users may not use shared accounts.
- Users outside the firewall protected network will have access through industry standard VPN with high encryption transmission.
- All database backups are performed with encryption to ensure they cannot be read by unauthorized users.

Community Health Solutions of Louisiana (CHS-LA)
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- All tables holding Patient Electronic Medical Record data have an audit table associated to redundantly track all Create and Update activity.
- All material is printed within a secured environment. By policy, no printed material is allowed to leave the secure environment. Each employee signs a confidentiality agreement upon joining the firm and undergoes HIPAA re-training annually. All material that is discarded is disposed of through secure shredder bins which are emptied onsite by Iron Mountain Secure Shredder.
- Users that view and change data do so through application interfaces which are controlled by role based function/action security. This confirms users may only access and change data as authorized. Applications by policy are re-credentialed annually.
- Viewing of Protected Health Information (PHI) or confidential data contained within reports is controlled by Active Directory roles. Users are tied to roles and roles are tied to the allowable reports.
- For additional HIPAA security, workstation displaying PHI are located within secured areas. Additionally, workstations are set to automatically lock should they go idle.

Community Health Solutions of Louisiana (CHS-LA)
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Section R: **Added Value to Louisiana**

Requirement R.1: *The “value added” from Provider Incentive Payments will be considered in the evaluation of Proposals. Responses to this section (which can be considered Proprietary) will be evaluated based solely on the quantified payment amounts reported herein, based on projected utilization for 75,000 members, and within the guidelines of the CCN program. Any cost savings associated with any quality or incentive program shall not be included in this response and will not be considered in the evaluation of this factor.*

See Appendix HH for instructions for completing the Provider Incentive Payments for Provider Incentives and Enhanced Payments.

The completed template (Attachment FF) and all additional documentation and calculations shall be accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information.

Response: Our initial thought process of “value added” for Provider Incentive payments is below. However, since we are still evaluating the impact on rates and have just begun to engage an actuary, the incentive payments below are preliminary.

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Louisiana Coordinated Care Networks - Shared
 Provider Incentive Programs

Louisiana Coordinated Care Networks - Shared
 Provider Incentive Programs

PER MEMBER PER MONTH PAYMENTS

Service	Description of Payment Methodology	PMPM								
		Children and Families								
		Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9
Physician - Primary Care	SSI Related Population	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50
Total		\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50
Projected Enrollment										

Service	Description of Payment Methodology	PMPM								
		Children and Families								
		Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9
Physician - Primary Care	SSI Related Population	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50
Total		\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50

Community Health Solutions of Louisiana (CHS-LA)
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 Geographic Service Area: A, B, C

Louisiana Coordinated Care Networks - Shared
 Provider Incentive Programs

BONUS PAYMENTS

PMPM										
Children and Families										
Children (Ages 0 - 18)										
Service	Description of Payment Methodology	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9
Physician - Primary Care for TANF/LaCHIP & SSI	After hours - Access & Availability	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20
Physician - Primary Care for TANF/LaCHIP & SSI	Urgent Care Services access & availability	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20
Physician - Primary Care for TANF/LaCHIP & SSI	EHR Meaningful use	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20
Physician - Primary Care for TANF/LaCHIP & SSI	NCQA PCMH Recognition	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20
Total		\$0.80	\$0.80	\$0.80	\$0.80	\$0.80	\$0.80	\$0.80	\$0.80	\$0.80
Projected Enrollment										

PMPM										
Children and Families										
Adults (Ages 19+)										
Service	Description of Payment Methodology	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9
Physician - Primary Care for TANF/LaCHIP & SSI	After hours - Access & Availability	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20
Physician - Primary Care for TANF/LaCHIP & SSI	Urgent Care Services access & availability	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20
Physician - Primary Care for TANF/LaCHIP & SSI	EHR Meaningful use	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20
Physician - Primary Care for TANF/LaCHIP & SSI	NCQA PCMH Recognition	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20
Total		\$0.80	\$0.80	\$0.80	\$0.80	\$0.80	\$0.80	\$0.80	\$0.80	\$0.80

Community Health Solutions of Louisiana (CHS-LA)
 CCN-S Proposal Submission
 Geographic Service Area: A, B, C

Louisiana Coordinated Care Networks - Shared
 Provider Incentive Programs

PAY FOR PERFORMANCE INCENTIVE PAYMENTS

PMPM												
Children and Families												
Children (Ages 0 - 18)												
Service	Description of Payment Methodology	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9		
Physician - Primary Care for TANF/LaCHIP & SSI	10 Clinical Performance Indicators	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20
Total		\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20
Projected Enrollment												
PMPM												
Children and Families												
Adults (Ages 19+)												
Service	Description of Payment Methodology	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9		
Physician - Primary Care for TANF/LaCHIP & SSI	10 Clinical Performance Indicators	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20
Total		\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20	\$0.20